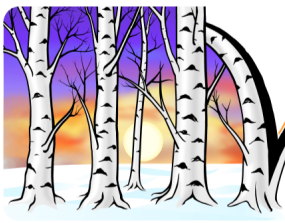


Woodland Wellness Center

Automobile Accident Intake Form

Name:_____ **Date of Birth**_____

Date of Accident: _____ **Time of Accident**: _____am/pm □ Daylight □ Dawn □ Dusk □ Dark

List the year, make and model of the car *you* were in: Year_____ Make_____ Model_____

Was the accident on the job? □ Yes □ No **Were you in a company vehicle?** □ Yes □ No

Was your car stopped at the time of impact? □ Yes □ No

If your car was moving at the time of impact was it: □ Slowing Down □ Accelerating □ Going at a Steady Speed

Road Conditions at time of the accident: □ Wet □ Dry □ Snow □ Ice □ Other_____

Did the police come to the accident scene? □ Yes □ No **Is there a police report?** □ Yes □ No

Were you aware of the approaching collision prior to impact, or did it catch you by surprise? □ Aware □ Surprise

Where were you seated in the vehicle? □ Driver □ Passenger □ Rear Seat □ Other_____

Were you wearing a seatbelt? □ Yes □ No If yes, did you receive a bruise or injury from it? □ Yes □ No

Was the seat adjustment altered by the accident? □ Yes □ No Was the seat Broken by the accident? □ Yes □ No

Did the airbag deploy? □ Yes □ No If yes, did it strike you? □ Yes □ No If yes, where? _____

Were you wearing a hat or glasses at the time of impact? □ Yes □ No

If yes, were they still on after the accident? □ Yes □ No

Did your head hit the headrest during the accident? □ Yes □ No

Which way was your head pointing at the point of impact? □ Straight □ Right □ Left □ Other_____

If adjustable, was the position of the headrest altered? □ Yes □ No

How was your body positioned at the point of impact? □ Straight □ Right □ Left □ Other_____

Where were your hands?

_____

Name:_____ Date_____

Did you lose consciousness upon impact? □ Yes □ No
Did you experience a flash of light or explosion in your head? □ Yes □ No
At the time of the accident, did you become or experience any of the following? □ Confused □ Disorientated
□ Light Headed □ Blurred Vision □ Ringing/Buzzing in Ears □ Loss of Balance □ Other_____
Do you still have any of these symptoms? □ Yes □ No Which ones?
_____
Check symptoms you have noticed since the accident:

□ Headaches/Migraines	□ Neck Pain	□ Upper Back Pain	□ Mid Back Pain	□ Shoulder Pain
□ Low Back Pain	□ Depression	□ Buzzing in Ears	□ Arm/Leg Pain	□ Jaw Pain/ Clicking
□ Dizziness	□ Fatigue	□ Loss of Memory	□ Cold Hands/ Feet	□ Numbness/ Tingling
□ Loss of Smell	□ Irritability	□ Digestive Problems	□ Joint Pain/ Stiffness	□ Menstrual Problems
□ Pinched Nerve	□ Loss of Sleep	□ Loss of Balance	□ Chest Pain	□ Light Sensitive Eyes
□ Fever	□ Nervousness	□ Vision Problems	□ Urinary Problems	□ Sleeping Problems
□ Paralysis	□ Tension	□ Fainting	□ Pins/ Needles Feeling	□ Upset Stomach
□ Difficulty Swallowing	□ Sciatica	□ Sinus Pain	□ Sore Muscles	□ Yes □ No
Other:				

Did you go to the Hospital? □ Yes □ No When? □ Immediately □ ____Hours Later □ ____Days Later
Which Hospital? _____ How did you get there? _____ How long did you stay there? _____
What did the Hospital do for your injuries? (collar, splint, x-rays, medication, ect.)
_____
What areas were x-rayed?_____ What was the diagnosis?_____
What did they recommend for follow-up care?
_____
Was any other Doctor consulted after your accident? □ Yes □ No If yes, please complete the information below:
Dr:_____ Specialty:_____ Date First Seen:_____
Type of Treament:_____ Treatment Frequency:_____

Name:_____ Date:_____

List the year, make and model of the *other vehicle*: Year_____ Make_____ Model_____

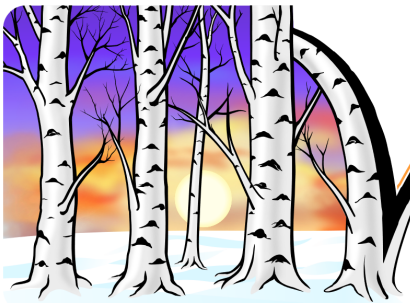
Was the other vehicle moving at the time of impact? □ Yes □ No If yes, what was the speed of the vehicle? ____mph

If the other car was moving at the time of impact was it: □ Slowing Down □ Accelerating □ Going at a Steady Speed

Please describe to the best of your knowledge what happened during the accident.

_____
_____
_____
_____
_____
_____
_____
_____

You may use the space below to draw the accident.



Woodland Wellness Center

376 Layla Court Fairbanks, Alaska 99712
(907) 456-1571

Date: _____

Confidential Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____ Work Phone:_____

City: _____ State:____ Zip:_____ Cell Phone: _____

SSN: _____ Email: _____

Sex: ◯Female ◯Male ◯Unspecified

Marital Status:_____

Emergency Contact:_____ Phone:_____

Are your present symptoms or condition related to, or the result of an auto collision, work-related injury or other? personal injury? (Someone else might be responsible for payment?) ___ Yes ___No

Primary

Ins. Company: _____ Ins. Phone #: _____

ID#: _____ Group #: _____

Name of Policy Holder: _____ **Policy Holder DOB:** _____

Relationship to Policy Holder: _____

Secondary

Ins. Company: _____ Ins. Phone #: _____

ID#: _____ Group #: _____

Name of Policy Holder: _____ **Policy Holder DOB:** _____

Relationship to Policy Holder: _____

Who may we thank for referring you? _____

How did you hear about our practice? ◯Radio Ad ◯Website ◯Google ◯Friend/Family ◯Other_____

376 Layla Court Fairbanks, Alaska 99712
(907) 456-1571

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to Woodland Wellness Center all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from Woodland Wellness Center and providers. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize Woodland Wellness Center to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from Woodland Wellness Center in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize Woodland Wellness Center to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to Woodland Wellness Center and providers to the fullest extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from Woodland Wellness Center and providers and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with the Woodland Wellness Center and providers in any attempts by Woodland Wellness Center to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with Woodland Wellness Center and providers against such insurers and/or employee health care plan in my name should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan please advise and disclose to my provider in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I have read and fully understand this agreement.

Print Name_____ Date_____

Signature of Insured / Guardian_____

HIPAA Notice of Privacy Practices

Woodland Wellness Center, Inc.
376 Layla Ct,
Fairbanks, AK 99701
(907) 456-1571

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.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment:

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral inmates, and required uses and disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 165.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your rights:

The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information.
Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information. You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively (i.e. electronically).

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

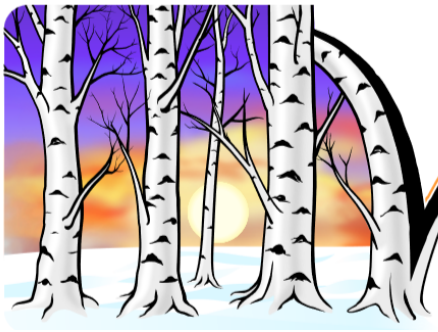
Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will NOT retaliate against you for filing a complaint.

This notice was published and becomes effective on/before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number listed at the top of the first page of this notice.

Signature_____ Date_____
Signature is acknowledgement that you have received this Notice of Privacy Practices.



Woodland Wellness Center

Thank you for choosing us as your health care provider. We appreciate your trust in us and the opportunity to serve you.

Please read and initial our service policy.

_____As a complimentary service, we will bill the patient's insurance carrier, however, patients are ultimately responsible for payment of treatment and care. It is the patient's responsibility for providing us with correct and updated insurance information. Please contact your insurance carrier with any questions that you may have regarding your coverage of treatment and services.

_____We will verify insurance coverage, but *it is not a guarantee of payment*. Please note that insurance benefit plans vary, and not all services provided at the Woodland Wellness Center are approved and/or covered.

_____ If a patient's insurance carrier does not pay a claim within 90 days, *or,* if the insurance carrier deems treatment as "Not Medically Necessary," and/or the treatment is not covered by the patient's insurance plan, the patient agrees to assume full financial responsibility for the health-related services they have received.

_____ It is our policy to collect payment at the time treatment services are rendered. Patients are responsible for co-pays, co-insurance, deductibles, as well as fees for treatment services or supplies not approved or covered by their insurance plan(s). As a courtesy to our patients, our fee schedule is posted in the waiting area, and the patient may request an estimate of anticipated charges.

____Most insurance companies require a referral for treatment to be on file. If this referral is from a provider outside the Woodland Wellness Center, it is the patient's responsibility to provide us with a copy of one.

_____When a patient has accrued an outstanding balance of $2500 or more, we may encourage the patient to follow up with their insurance carrier. At this point, we reserve the right to collect payment, by any legal means necessary, before any further services are provided.

_____Woodland Wellness Center's contracted providers reserve the right to deny any services.

_____Woodland Wellness Center's cancellation policy requires patients to call 24 hours in advance if an appointment must be cancelled. Patients who do not call *and* do not show up for their scheduled appointment will be charged a $50 cancellation fee.

We understand that temporary financial problems may affect timely payment of your balance. We ask that you speak with an Account Manager if you encounter such problems, so that we may assist you in the management of your account.

Print Patient Name_____

Patient Signature_____ Date_____