Health Moves

"The Way to Wellness"

PATIENT INFORMATION

Today's Date ______________________

Name ______________________ Age ________ Birthdate ______________________

Address ______________________ City ____________ State ____ Zip ______

Home Phone ____________ Work Phone ____________ Cell Phone ____________

Fax ____________ Email ______________________ SSN ____________

Sex: M F Marital Status: Single Married Divorced Widowed Separated

Occupation ____

Employer (Name & Address) ____

Emergency Contact ______________________ Phone Number ______________________

Who may we thank for referring you to our office? ______________________

INSURANCE INFORMATION

Name of your insurance company (regardless of fault) ______________________

Claims Address ______________________ City ____________ State ____ Zip ______

Phone Number ____________ Medical Claims Adjuster's Name ____________

Claim Number ____________ Name of the Driver of the Other Vehicle ____________

Their Insurance Company ____________ Policy Number ____________

PERSONAL INJURY QUESTIONNAIRE

Date of Accident: ______________________ Time of Day: ______________________ am pm

Were the police notified? Yes No If yes, investigation by ______________________

Were there any witnesses? Yes No Names ______________________

Have you retained an attorney? Yes No Name ______________ Phone Number ____________

Were you Driver Passenger Front Seat Back Seat Number of people in your vehicle ____________

Number of people in other vehicle ________ Did your air bag deploy?____ If so, which one(s)? ____________

Road conditions at time of accident: Wet Dry Icy Other ______________________

Road surface: Asphalt Gravel Dirt Other ______________________

What direction were headed? N S E W Name of street ______________________

What direction was the other vehicle headed? N S E W Name of street ______________________

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Were you struck from: Behind Front Left Side Right Side

Were you wearing a seatbelt? No Yes If yes: Lap Belt Only Shoulder and Lap Shoulder Belt Only

Any bruising or soreness from the seat belt? No Yes, explain ______

What was your position at the time of impact? Facing Straight Ahead Head Turned Right Left

Does your car have a headrest? No Yes

If yes, approximately how far was the top of the headrest from the top of your head? ______inches Above Below

Were you knocked unconscious? No Yes If yes, for how long? ______

Were you aware of the approaching collision prior to impact? No Yes

If yes, did you try to brace yourself prior to impact? No Yes, How? ______

Was your car stopped at the time of impact? No Yes If yes, was the driver's foot on the brake pedal? No Yes

Clutch pedal? No Yes If yes, did your car move forward upon impact? No Yes

If no, were you: Gaining Speed Slowing Down Traveling Steady Rate of Speed: Slow Medium Fast

Did your vehicle strike another car? No Yes Did your vehicle strike another object? No Yes, ______

Was the other vehicle moving at the time of collision? No Yes

If yes, at the time of impact was the other vehicle traveling: Slow Medium Fast

If yes, was the other vehicle: Gaining Speed Slowing Down Traveling at a Steady Speed

What type of car were you driving? ______

What type of car impacted with your vehicle?

In your own words, please describe the accident (include what you saw or felt): ______

______

Describe how you felt (did you feel pain):

DURING the accident: ______

IMMEDIATELY AFTER the accident: ______

LATER THAT DAY: ______

THE NEXT DAY: ______

Other: ______

What is the estimated cost of damage to your vehicle? ______

Do you have a photo of the damage? [ ] No [ ] Yes

On what part of the automobile did the following body parts hit?

Head Hit: ______ Chest Hit: ______

Right/Left Shoulder Hit: ______ Right/Left Arm Hit: ______

Right/Left Hip Hit: ______ Right/Left Leg Hit: ______

Right/Left Knee Hit: ______ Other: ______

Which of the following car parts broke during the accident?

Windshield   Front Seat Back   Right/Left Side Window   Steering Wheel   Other: ____________

Did you have any physical complaints BEFORE THE ACCIDENT?   No   Yes, describe in detail: ____________

____

What are your PRESENT complaints and symptoms? ____________

____

Do you have any congenital (from birth) factors that relate to this problem?   No   Yes, explain: ____________

____

Do you have any previous illnesses relating to this case?   No   Yes, ____________

Have you ever been involved in an accident before?   No   Yes   If yes, describe including date(s), type(s) of accidents and injury(s) received: ____________

____

Did you receive medical care immediately following the accident?   No   Yes   If yes, describe where, type of treatment and doctor's name: ____________

____

Have you been treated by another doctor since the accident?   No   Yes   If yes, list the doctor's name, address and phone:

____

What type of treatment did you receive? ____________

Since this injury occurred are your symptoms: Improving   Getting Worse   Same

CHECK SYMPTOMS THAT YOU HAVE NOTICED SINCE THE ACCIDENT:

Headache	Arm Pain	Fatigue	Face Flushed
Neck Pain	Leg Pain	Diarrhea	Cold Sweats
Neck Stiffness	Chest Pain	Constipation	Depression
Upper Back Pain	Loss of Taste	Sleeping Problems	Nervousness
Mid-Back Pain	Memory Loss	Head Seems too Heavy	Feet Cold
Lower Back Pain	Loss of Balance	Pins & Needles in Arms	Hands Cold
Hip Pain	Loss of Smell	Pins & Needles in Legs	
Knee Pain	Dizziness	Numbness in Fingers	
Foot Pain	Fainting	Numbness in Toes	
Shoulder Pain	Fever	Shortness of Breath	
Elbow Pain	Ears Ringing	Light Bothers Eyes	
Wrist Pain	Irritability	Emotions out of Control	

Symptoms other than above: ____________

____

Employer: ____________________ Type of Employment: ____________________

Have you lost time from work as a result of this accident? No Yes

If yes, when was the last day you worked? ____________________ Number of days missed: __________

If yes, are you being compensated for time lost from work? No Yes, type of compensation you are receiving:

____

Do you notice any activity restrictions in your capacity for work, family or recreational pursuits as a result of this injury?

[ ] No [ ] Yes If yes, describe in detail: ____________________

____

Other pertinent information: ____________________

____

Date: ____________________ Patient's Signature: ____________________

PAIN RATING AND LOCATION SCALE

MY CHIEF COMPLAINT IS: ____________________

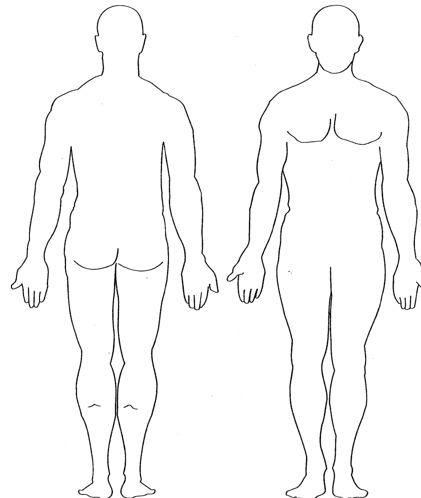
2nd COMPLAINT: ____________________

3rd COMPLAINT: ____________________

PLEASE DRAW THE LOCATION AND TYPE OF PAIN ON THE BODY OUTLINES:

Ache	**Burning**	**Numbness**
MMMM	OOOOO	NNNNN

Pins and Needles	**Stabbing**	**Other**
● ● ● ● ● ●	/////	XXXXX



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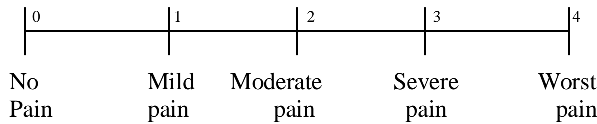
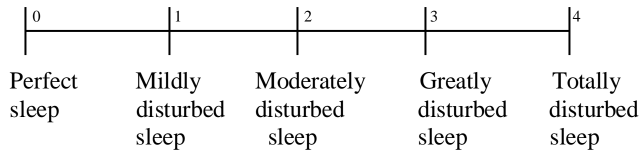
FUNCTIONAL RATING INDEX

In order to properly assess your condition, we must understand how much your pain has affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

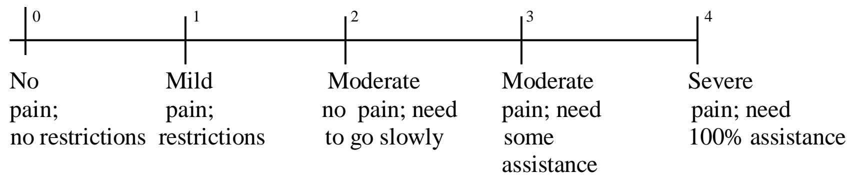
1. PAIN INTENSITY



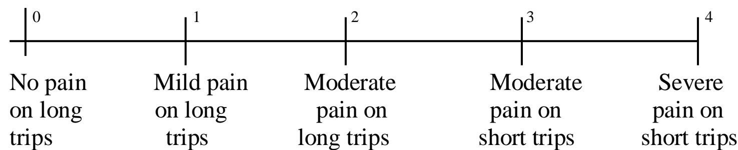
2. SLEEPING



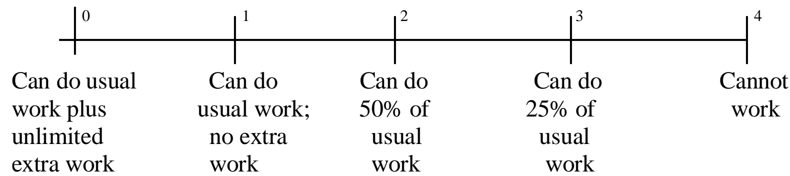
3. PERSONAL CARE



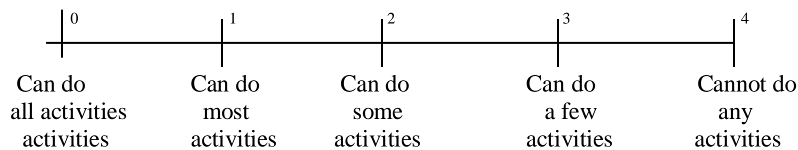
4. TRAVEL



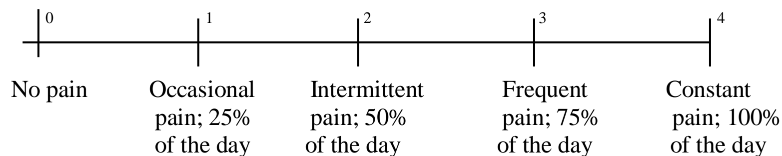
5. WORK



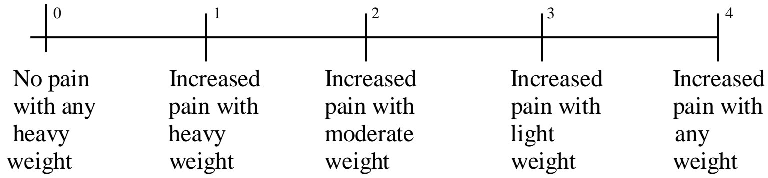
6. RECREATION



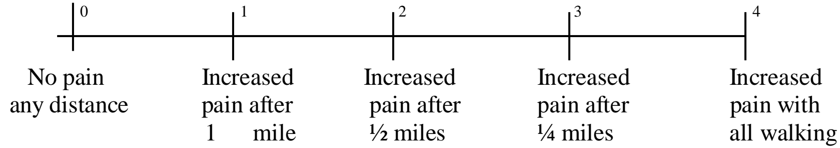
7. FREQUENCY OF PAIN



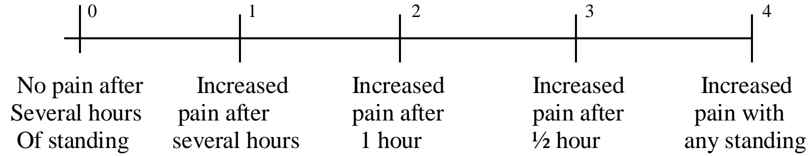
8. LIFTING



9. WALKING



10. STANDING



The starred items below must be filled out in order to obtain prior-authorization for acupuncture from your insurance company.

Rate your pain level on a scale of 1-10 (10 is the worst pain):

* Rate your pain prior to starting treatments:

* Rate your pain after starting treatments:

* Please list ways your treatments are improving your symptoms (i.e. frequency, intensity and ability to perform daily activities):

____

____

How many hours can you currently work? ________ hours per day ______ hours per week

What dates were you unable to work at all _____________ to________________

What dates did you work with limited work capacity ________ to____________

How many hours were/are you able to work? _______ hours per day

What is the main reason for your visit today?

____
____
____
____
____
____
____
____
____

Other conditions / concerns for future discussion?

____
____
____
____
____
____
____
____

Other Healthcare Providers:

Dr. ______________ for ______________ Dr. ______________ for ______________

Dr. ______________ for ______________ Dr. ______________ for ______________

Dr. ______________ for ______________ Dr. ______________ for ______________

____

Medications / Supplements

Name________________Dose ________
Name________________Dose ________
Name________________Dose ________
Name________________Dose ________
Name________________Dose ________
Name________________Dose ________
Name________________Dose ________
Name________________Dose ________
Name________________Dose ________
Name________________Dose ________

Medication Allergies

☐ None

Drug________________Reaction ________
Drug________________Reaction ________
Drug________________Reaction ________
Drug________________Reaction ________
Drug________________Reaction ________
Drug________________Reaction ________
Drug________________Reaction ________
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Drug________________Reaction ________
Drug________________Reaction ________

Health Moves
"The Way to Wellness"

Clinic Policy and Treatment Agreement

Thank you for choosing Health Moves as your way to wellness. We offer comprehensive naturopathic medicine, acupuncture treatments and consultations.
Acceptance: I hereby request acceptance by Health Moves PLLC as a patient for the initial purpose of disclosing my health history and thereby facilitating a physical examination to address the symptom(s) I have been experiencing, which led to my seeking health care services.
Treatment Authorization: I hereby authorize Health Moves PLLC to administer treatment services as indicated by a Health Moves PLLC designated doctor.
Dispensary Items: Dispensary items are of the highest quality and are available on site for your convenience. They may be purchased elsewhere as long as you use the same brand and dosage as prescribed. Prices are generally lower than can be found for these brands elsewhere.
Phone Consultations: Health Moves does not charge additionally for calls regarding clarification of current treatment plans, dispensing questions or if the doctor has requested you call. New concerns are billed from $25 - $55 depending upon complexity**.** Please note that this service is ***not*** covered by insurance plans and will be billed to you directly.

INSURANCE

Release of Confidential Information: I hereby authorize Health Moves to release my medical information to my insurance company as needed to process my claims. I understand that Health Moves bills my insurance company as a courtesy to me without charge. I understand that in the event my insurance company does not cover medical costs I am responsible for payment in full.
PIP Personal Injury: If you have been in an accident and would like acupuncture and/or naturopathic physical medicine treatment for your injuries, please indicate this to us before your visit. Call your insurance company and let them know you are choosing this type of care. Bring your open & active insurance information and your claim number.
Referral: If your insurance company requires a referral please request a referral from your primary care physician prior to your appointment with Health Moves.

FINANCIAL RESPONSIBILITY

Liability of Patient: In consideration of my admission to treatment as a patient and of the services to be rendered, I hereby individually obligate myself to pay my account in accordance with regular rates and terms.
Liability of Other Signatories: In consideration of the acceptance of the designated patient as a patient and of the services to be rendered, I hereby individually obligate myself to pay the designated patient's account in accordance with regular rates and terms.
Payment Terms: Payment is due at the time of service unless alternate arrangements have been made *prior* to your appointment. As a courtesy we will verify your insurance coverage prior to your visit whenever possible but this is not a guarantee that services are covered by your specific plan. However, it is important that you understand your policy and any possible limitations of coverage. We will also bill your insurance company as a courtesy service. You will be responsible for all co-pays and deductibles at the time of service. I have been informed that this handling fee is not a covered service under my insurance and I agree to be financially responsible for these charges.
Method of payment: Cash, Check, Visa or MasterCard are accepted.
Interest: Outpatient charges are due in full for each increment of service as rendered and that any unpaid balance on the account(s) for which I am liable bear(s) interest at the highest allowable rate per month.
Cancellation & Late Policy: All patients will be seen at their scheduled appointment time. In the event you are late, the time will be deducted from your visit rather than run over to the next patients. If you need to cancel and reschedule your appointment for another time, please do so 24 hours prior to your scheduled appointment time. If we do not receive notification of cancellation 24 hours prior to your scheduled appointment time, you will be billed as stated below which is not covered by your insurance and will be your responsibility.
Prices & fees are subject to change without notice.

Late cancellation/no show fee $55 ____ (Please initial)   **No show First Office Visit fee $120**____ (Please initial)

Patient____   **Date** __________________

Health Moves

"The Way to Wellness"

PIP BILLING

What is PIP?

- Personal Injury Protection is a part of your auto insurance policy. It is designed to take care of you immediately after an accident.

Benefits of PIP…

- PIP is no-fault, so it doesn't matter who caused the accident. You are still covered.
- Most PIP coverage is for one year or $10,000, whichever comes first. Some policies have higher limits.
- PIP covers medical payments, wage loss and loss of services. There is no deductible.

What is Med Pay?

- Med Pay is a medical-payments-only version of PIP. It does not cover wage loss or loss of services.

A Step-By-Step Guide

1. Call your insurance agent.
2. Ask if you have PIP or Med Pay.
3. Ask about limits on time and dollar amount.
4. Ask your agent to take your report of loss and call it into the claims office.
5. Ask your agent to call back with the claim number, address and the phone number of the claim office.
6. Call the claims office and get the name of the claims adjuster handling your claim.
7. Ask the claims adjuster to mail a PIP Application, Attending Physician's Report and Salary Verification forms.
8. Complete the PIP application and return it to the claims adjuster.
9. Have your doctor fill out the Attending Physician's Report form and return it to you. Mail it to the claims adjuster.
10. Have your employer complete the Salary Verification form and return it to you. Mail it to the claims adjuster.
11. Provide your claim number and the adjustor's name, office address and phone number in the space provided below.

If you have any questions do not hesitate to ask.

Name of your Insurance Company: ______________________________________

Medical Claim Number: ____

Medical Adjuster's Name:____

Medical Adjuster's Phone Number: ____________________________________

Insurance Company's Address: _______________________________________

City, State, & Zip____

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PROMISE TO PAY ACCOUNT FORM PROCEEDS OF INJURY CLAIM

I, _________, do hereby authorize and direct my attorney to take any proceeds of the lawsuit involving an automobile accident which caused bodily injury to me which occurred on or about ________ , and pay those proceeds which would otherwise be payable directly to me, to Health Moves PLLC until the amount owing for services rendered for my benefit, plus lawful interest, is paid in full.

This promise of payment will be null and void if the above-indicated provider sends my account to a collection agency or takes collection action prior to my case coming to a conclusion. If the case fails to produce sufficient funds to pay this promise, then the provider may consider me to be in breach of the promise to pay and take any collection action it deems appropriate.

This promise is irrevocable and will remain also a directive to any attorney I may have represent me in the future.

Dated this ______ day of_________________ , 20 ____.

____
PATIENT SIGNATURE

We acknowledge and accept this directive of our client.

Dated this ______ day of_________________ , 20 ____.

____
AUTHORIZED HEALTH MOVES ASSOCIATE SIGNATURE

Sent to Attorney: