

**Hazel Dell Sports Medicine & Rehab Clinic/DBA Forgey SportsMed & Rehab Clinic
1503 NE 78th St., Ste. # 9, Vancouver, WA 98665 360-573-5500**

PLEASE FILL OUT COMPLETELY

PATIENT INFORMATION

Name: _____

 LAST FIRST MI

I prefer to be called: _____ Male Female

Birthdate: ____/____/____ Age: ____ SS#: _____

Home Address: _____
 _____ Apt#: _____

City State Zip

Mailing Address if different than above: _____
 _____ Apt# _____

City State Zip

Single Married Divorced Widow Separated Student

Hm #: () _____ Cell #: () _____

Wk #: () _____ Ext: _____ DL#: _____

Employer: _____

Employer's Address: _____

Email Address: _____

Would you like to receive our monthly newsletter? Yes No

How did you hear about our office? Web / Google / Insurance /
 Yellow Pages / Friend or Family member

Name: _____

SPOUSE/GUARDIAN INFORMATION

(Circle one)

His/Her Name: _____

Relation: _____

Employer: _____

Hm #: _____ Cell #: _____

Wk #: () _____ Ext. _____

Birthdate: ____/____/____

SS#: _____

PERSON RESPONSIBLE FOR ACCOUNT:

Name: _____

Relation: _____ Ph#: _____

Billing Address: _____

**In the event of an emergency, is there someone
not living with you that we can contact?**

His/Her Name: _____

Relation: _____

Hm #: _____ Cell #: _____

My Financial Responsibility

I certify that the above information is true and correct to the best of my knowledge and hereby authorize this office to do whatever is necessary in accordance with state statutes for the care and management of my complaints. I understand and agree that I am ultimately **financially responsible** for all services.

X _____
 Signature of patient or person acting on patient's behalf Date

INSURANCE INFORMATION

Patient Last Name _____ First Name _____ MI _____ DOB: _____

Insurance Type Check all that apply

Private Health Insurance Medicare Medicaid(DSHS) Personal Injury (auto, etc.) Workers Compensation

PRIVATE HEALTH INSURANCE (Please provide us with a copy of your insurance card(s) for our records)

<u>Primary Insurance</u>	<u>Secondary Insurance</u>
Insurance Co. Name: _____	_____
Insurance Co. Phone #: () _____	() _____
Insured's Name: _____ DOB: _____	_____ DOB: _____
Insured's ID #: _____ Group #: _____	ID#: _____ Group #: _____
<u>Patient's Auto Insurance (PIP) (if applicable)</u>	<u>Insurance Party At Fault</u>
Insurance Co. Name: _____	_____
Insured's Name: _____	_____
Insurance Co. Phone #: () _____	() _____
Claim #: _____	_____
Date of Accident: _____	City & State where the accident occurred: _____
Was the accident your fault? Yes No	Attorney's Name: _____
<u>Worker's Compensation Insurance (if applicable)</u>	
Employer's Name: _____	Claim #: _____ DOI: _____
Work Comp Insurance Co: _____	Phone #: _____
Attorney's Name: _____	
Have you been treated anywhere else for this injury? Yes No If so, where?: _____	

My authorization

I authorize the **release** of any medical or other information necessary to process my claims. I also **request** payment of government or private benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the physician or supplier for services received. This is a permanent authorization that I may revoke at any time by written notice.

x _____
Signature of patient or person acting on patient's behalf Date

My Financial Responsibility

I certify that the above information is true and correct to the best of my knowledge and hereby authorize this office to do whatever is necessary in accordance with state statutes for the care and management of my complaints. I understand and agree that I am ultimately **financially responsible** for all services not paid for by my insurance. I am also responsible for any annual deductibles applicable, co-payments, or non-covered services as may be required by my insurance plan.

x _____
Signature of patient or person acting on patient's behalf Date

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Thank you for allowing Forgey SportsMed & Rehab to assist you with your care. As a courtesy to you we will bill your insurance. If there are any changes in your insurance, please let us know immediately so we can submit your claim properly. We have prepared the following financial policy in order to help our patients determine their responsibility for payment of Chiropractic and Physical Therapy Services.

_____ Co-Pays are due at the time of service, unless prior arrangements have been made. You will begin receiving
Initial A monthly statement with any balances after your insurance company has been billed.

_____ Chiropractic Adjustments & Physical Therapy (ice, electric stim, myofascial, etc.) are separate charges.
Initial

PRIVATE PAY/ CASH PATIENTS: If you do not have health insurance, you will be responsible for health care expenses and will make sure your account is kept current or have made payment arrangements that are suitable for all parties. Our office's "Cash at time of Service" fees are possible due to the minimal amount of patient billing required.

HEALTH INSURANCE: This office will cooperate in processing your insurance claim and will wait for payment by your insurance company. If your insurance company does not pay within 60 days from the date of treatment, or does not pay the balance due, you will be held responsible to pay the office directly. A telephone quote is usually the way we obtain medical benefits and eligibility, however this does not necessarily mean your insurance company will approve treatment or guarantee payment of services. You are ultimately responsible for any deductibles, co-pays or any portion that your insurance does not cover.

MEDICARE OR MEDICARE REPLACEMENT: Medicare will only pay for Active treatment spinal manipulation. Medicare will not pay for exams, x-rays or maintenance chiropractic care. You will be responsible for any deductibles, co-pays or co-insurance. We will bill any secondary insurance for you.

ACCIDENT CASES (AUTOMOBILE ACCIDENT, FALL, ETC.): If the auto accident was not your fault you must still notify your auto insurance company so they are aware of the accident and can provide you with a claim number for your medical bills to be paid. This is standard procedure with insurance companies: your insurance company will pay your medical bills up front and will be reimbursed from the at-fault company when your claim is settled. If someone else injures you, and you do not have insurance to cover your services, our office may cooperate with you in processing your claim against the person who injured you. We may agree to wait for payment of your bill from the proceeds of any settlement or judgment. However, you are still responsible for full payment whether or not you collect from the other party, or their insurance. If we do agree to wait, you and or your attorney must cooperate with the clinic and sign an assignment of the insurance or settlement proceeds, so payment will be made directly to Hazel Dell Sports Medicine/Forgey SportsMed & Rehab.

INJURIES AT WORK: If you have been injured while on the job and your injury has been accepted Hazel Dell Sports Medicine/Forgey SportsMed & Rehab Clinic will bill the workman's compensation carrier and no payment will be required. However, if your claim is denied or closed it will be your responsibility to pay for all bills incurred.

*There will be a \$ 35.00 fee for NSF checks (non-sufficient funds).

I have read and understand the above financial policy.

PRINT PATIENT NAME: _____ PATIENT SIGNATURE: _____ DATE: _____

Patient Privacy Summary

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION

We are required by law to have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and making a complaint if you think your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our Notice from time to time.

You have the right to receive a copy of our most current Notice in effect. If you have not yet received a copy of our current Notice, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the Notice or your medical information, Please contact our office at 360.573.5500.

I authorize release of my private health information to: _____
i.e. spouse/child/parent/other

I authorize release of my account information to: _____
i.e. spouse/child/parent/other

Relationship to patient: _____ Expires: _____

I wish to be contacted in the following manner: (check all that applies)

Home Telephone # (____)-_____
 Okay to leave detailed message
 Leave message with call back name
and number only

Written Communication
 Okay to mail to my home address
 Okay to mail to my work/office address
 Okay to fax to (____)-_____

Work Telephone # (____)-_____
 Okay to leave detailed message
 Leave message with call back name
and number only

Cellular Telephone # (____)-_____
 Okay to leave detailed message
 Leave message with call back name
and number only

Patients Name: _____

Signature of Patient or Person acting on Patient's behalf

Date:

FORGEY SPORTSMED & REHAB CLINIC, PLLC
 1503 NE 78th ST., Ste. # 9, Vancouver, WA 98665 360-573-5500 360-573-9075 Fax
 www.sportsmedonline.net

RATE YOUR FUNCTION: Place an X on the line below representing your current level of function.

COMPLETE _____ NO
 FUNCTION _____ FUNCTION

Job Title: _____ Are you currently working: Yes _____ No _____

Check all appropriate: Full time _____ Full duty _____ Part time _____ Light Duty _____

Work Schedule: _____

Describe your job duties: _____

Maximum Lifting up to _____ lbs Occasional Lifting up to _____ lbs

If newly employed list employers name, job title, and duties: _____

RATE YOUR PAIN: Place an X on the line below representing your current level of pain.

PAIN _____ WORST POSSIBLE
 FREE _____ PAIN

Mark the areas on your body where you feel your pain. Include all affected areas. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

<p>Ache: >>></p> <p>Numbness: ===</p> <p>Pins/Needles: ooo</p> <p>Burning: xxx</p> <p>Stabbing: ///</p> <p>Throbbing: ~~~</p>		<p>Mark the appropriate selection below.</p> <p>The pain is worse:</p> <p>() first wake () morning () mid day () afternoon () evening () bedtime</p> <p>The pain is least:</p> <p>() first wake () morning () mid day () afternoon () evening () bedtime</p>
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Frequency of pain: () Intermediate 25% () Occasional 25-50% () Frequent 50-75% () Constant 75%

Average time of day in pain: () <1 hr () 1-4 hrs () 4-8 hrs () when not lying down () 24 hrs

What activities make the pain better: _____

What activities make the pain worse: _____

RATE YOUR ACTIVITY FUNCTION: Place an X on the line below representing your current level of function.

COMPLETE FUNCTION _____ NO FUNCTION

Patient Name: (Print) _____

Patient Name: (Signature) _____ Date: _____

Forgey SportsMed & Rehab Clinic

1503 NE 78th. St. Suite 9

Vancouver WA 98665

(360) 573-5500 Fax (360) 573-9075

www.sportsmedonline.net

Info@sportsmedonline

Privacy Notice **THIS NOTICE** **DESCRIBES HOW** **MEDICAL INFORMATION** **ABOUT YOU MAY BE** **USED AND DISCLOSED** **AND HOW YOU CAN GET** **ACCESS TO THAT** **INFORMATION.**

PLEASE REVIEW THIS NOTICE CAREFULLY.

The Forgey SportsMed & Rehab Clinic (FSMRC) is committed to maintaining the privacy of your protected health information (PHI), which includes information about your health condition and the care and treatment you receive from us. The creation of a record detailing the care and services you receive helps this clinic to provide you with quality health care. This Privacy Notice details how your PHI may be used and disclosed to third parties and also details your rights regarding your PHI.

DISCLOSURE FOR TREATMENT, PAYMENT, AND OPERATIONS PURPOSES:

FSMRC may use and/or disclose your PHI for the purposes of:

- (a) Treatment – In order to provide you with the health care you require, FSMRC will provide your PHI to those health care professionals, whether on FSMRC's staff or not, directly involved in your care so that they may understand your health condition and needs.
- (b) Payment – In order to get paid for services provided to you, FSMRC will provide your PHI, directly or through a billing service, to appropriate third party payers.
- (c) Health Care Operations – In order for FSMRC to operate in accordance with applicable law and insurance requirements and to provide quality and efficient care, it may be necessary for us to compile, use, and/or disclose your PHI.

NO CONSENT REQUIRED:

FSMRC may use and/or disclose your PHI without a written Consent from you in the following instances:

- (a) De-identified Information – Information that does not identify you and cannot be used to identify you.
- (b) Business Associate – To a business associate if FSMRC obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI.
- (c) Personal Representative – To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.
- (d) Emergency Situations –
 - (i) For the purpose of obtaining or rendering emergency treatment to you provided that we attempt to obtain your Consent as soon as possible; or
 - (ii) To a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.
- (e) Communication Barriers – If, due to substantial communication barriers or inability to communicate, we have been unable to obtain your Consent and we determine, in the exercise of our professional judgment, that your consent to receive treatment is clearly inferred from the circumstances.
- (f) Public Health Activities - Information collected by a public health authority, as authorized by law
- (g) Abuse, Neglect or Domestic Violence - To a government authority if FSMRC is required by law to make such disclosure.
- (h) Health Oversight Activities - Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, etc.
- (i) Judicial and Administrative Proceeding - FSMRC may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.
- (j) Law Enforcement Purposes - Your PHI may have to be disclosed to a law enforcement official if for example it is the subject of a grand jury subpoena.
- (k) Coroner or Medical Examiner – FSMRC may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.
- (l) Research – If FSMRC is involved in research projects your PHI may be used subject to numerous governmental requirements intended to protect the privacy of your PHI.
- (m) Avert a Threat to Health or Safety – FSMRC may disclose your PHI if we believe that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

- (n) Specialized Government Functions - Disclosures of PHI that relate to military and veteran activity.
- (o) Workers' Compensation - If you are involved in a Workers' Compensation claim, FSMRC may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.
- (p) National Security and Intelligence Activities – FSMRC may disclose your PHI in order to provide authorized governmental officials with for national security activities and purposes authorized by law.
- (q) Military and Veterans – If you are a member of the armed forces, FSMRC may disclose your PHI as required by the military command authorities.

APPOINTMENT REMINDERS:

FSMRC may, from time to time, contact you by telephone or mail to provide information about treatment alternatives or as an appointment reminder. We may leave a message on your answering machine or with the individual answering the phone.

DIRECTORY/SIGN-IN LOG:

FSMRC maintains a directory of and sign-in log for individuals seeking care and treatment in the office.

FAMILY/FRIENDS:

FSMRC may disclose to your family member, other relative, a close personal friend, or any other person identified by you, the PHI directly relevant to such person's involvement with your care or the payment for your care.

AUTHORIZATION:

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

YOUR RIGHTS:

You have the right to:

- (a) Revoke any Authorization and/or Consent, in writing, at any time.
- (b) Request restrictions on certain uses and/or disclosures of your PHI as provided by law.
- (c) Receive confidential communications or PHI by alternative means or at alternative locations.
- (d) Inspect and copy your PHI as provided by law.
- (e) Amend your PHI as provided by law.
- (f) Receive an accounting of disclosures of your PHI as provided by law.
- (g) Receive an expanded paper copy of this Privacy Notice.
- (h) Complaints may be made to Dr. Blessley, Dr. Forgey, or to the Secretary of HHS if you believe your privacy rights have been violated. All complaints must be in writing.
- (i) To obtain more information on, or have your questions about your rights answered; you may contact Dr. Blessley at (360) 573-5500, or via email to Dr. Blessley at info@sportsmedonline.net

FSMRC'S REQUIREMENTS:

- (a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing our legal duties and privacy practices with respect to your PHI.
- (b) Is required to maintain a higher level of confidentiality with respect to certain portions of your medical information which is provided for under federal law where state and federal laws conflict, and where state law is more stringent in the area of privacy.
- (c) Is required to abide by the terms of this Privacy Notice.
- (d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.
- (e) Any Privacy Notice changes will be displayed in our office lobby.
- (f) Will not retaliate against you for filing a complaint.

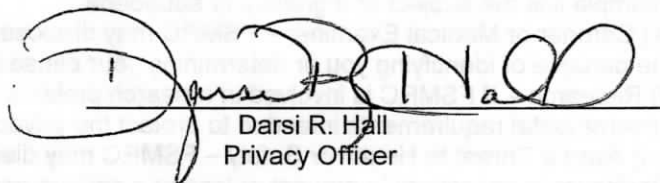
An expanded version copy of this Privacy Notice is posted in our lobby. You may have a copy of the expanded version to have for your personal use, just ask at the reception desk.

EFFECTIVE DATE:

This Notice is in effect as of 8/14/03



Douglas L. Forgey, DC
Owner/ Clinic Director



Darsi R. Hall
Privacy Officer