WILLOW TREE WELLNESS

Motor Vehicle Accident Intake Form

Information provided on this form is confidential. It is very important the information given is complete and accurate to assist you properly in your healing process.
Please look for Willow Tree Wellness on FB and join our online community for clinic announcements!

Today's Date ___/___/___

Name ______________________________ Date of Birth ___/___/___ Age:__________ Sex:__________

Address____

City/ State/ Zip ____________________________ email ______________________________

Telephone: (home)_______________ (work)_________________ (cell) ___________________

Emergency Contact Person/Relationship____

Phone #____

Who is your Primary Care Physician? ____

Referrals are the best compliments. Whom may we thank for your referral? ____________________

General Accident Information

Please briefly describe the accident: ____

____

____

____

____

What other treatments have you received since the accident?

____

What medications (prescribed or over the counter) herbs, vitamins, supplements, etc. are you currently taking?

____

____

____

What goals do you have for your acupuncture treatments? ____

____

Accident Site

Street Name and Nearest Intersection: ____

City/State: ____

Driving Conditions: ☐ Dry ☐Wet ☐Icy ☐Sunny ☐Other:____________________________________

Direction Headed: ☐North ☐South ☐East ☐West ☐Other: __________________________________

Approximate Speed: ____

Did any part of your body strike anything in the vehicle? Y N ___________________________________

Impact from: ☐Front ☐Rear ☐Left ☐Right ☐Other_______________________________________

Did the police come to the accident site? Y N Any witnesses? Y N

Police Report filed? Y N Any Traffic Violation issued? Y N If yes, to whom:____________________

Vehicles

Make and model of the vehicle you were in: ____

Where were you looking at the time of impact? ☐Straight ahead ☐Right ☐Left ☐Up ☐Down ☐Other________

Were you wearing a seatbelt? Y N

Were both hands on the steering wheel? Y N If no, which hand was on the steering wheel? ☐Left ☐Right

If the vehicle was equipped with airbags, did they inflate properly? Y N

Did your seat have a headrest? Y N If yes, what position? ☐Low ☐Middle ☐High

Was your foot on the brake? Y N If yes, which foot? ☐Left ☐Right

Were you: ☐Surprised by the impact ☐Braced for the impact

How many people were in the car you were in? __________

Which seat were you in? ☐Driver ☐Front Passenger ☐Left Rear Passenger ☐Right Rear Passenger

Was a pedestrian involved in the accident? Y N

Did the car you were in impact another vehicle or structure? ____________________________________

Make and model of other vehicle: ____

Direction other vehicle was headed? : ☐North ☐South ☐East ☐West ☐Other:

Speed? _________________________

Patient Condition

Were you unconscious after the accident: Y N If yes, for how long? ______________________

How did you feel immediately after the accident? ______________________

____

Did you go to the Hospital? Y N

When did you go? ☐Immediately ☐Next day ☐2 or more days after

How did you get to the hospital? ☐Ambulance ☐Private Transportation

Name of Hospital: ______________________ Treating Doctor: ______________________

Diagnosis: ______________________ Treatment Received: ______________________

X-rays taken? Y N Have you been able to work since this injury? Y N

When did you go back to work? ☐Immediately ☐Next day ☐Two or more days ☐I have not returned

Have you had any of the following symptoms since your injury?

☐Arm/Shoulder pain	☐Fatigue	☐Leg pain	☐Stomach upset
☐Anxiety/Depression	☐Feet/Toe numbness	☐Memory loss	☐Tension
☐Back pain/stiffness	☐Hand/Finger numbness	☐Nausea	☐Vision blurred
☐Chest pain	☐Headaches	☐Neck pain/stiffness	
☐Dizziness	☐Irritability	☐Shortness of breath	
☐Ear buzzing/ringing	☐Jaw problems	☐Sleep difficulties	

Is your condition getting progressively worse? Y N

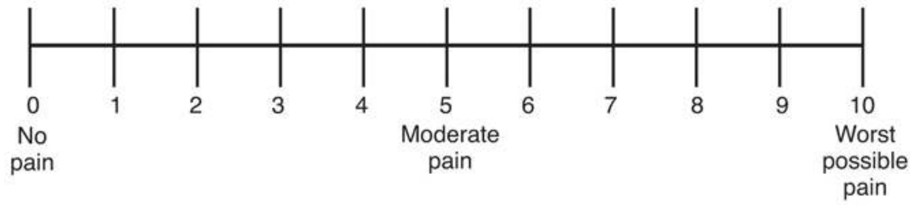
Comments: Please describe anything else you would like to discuss. ______________________

____

____

____

Rate the overall severity of your pain:



How often do you have this pain? ______________________________

Is it constant or does it come and go? ______________________________

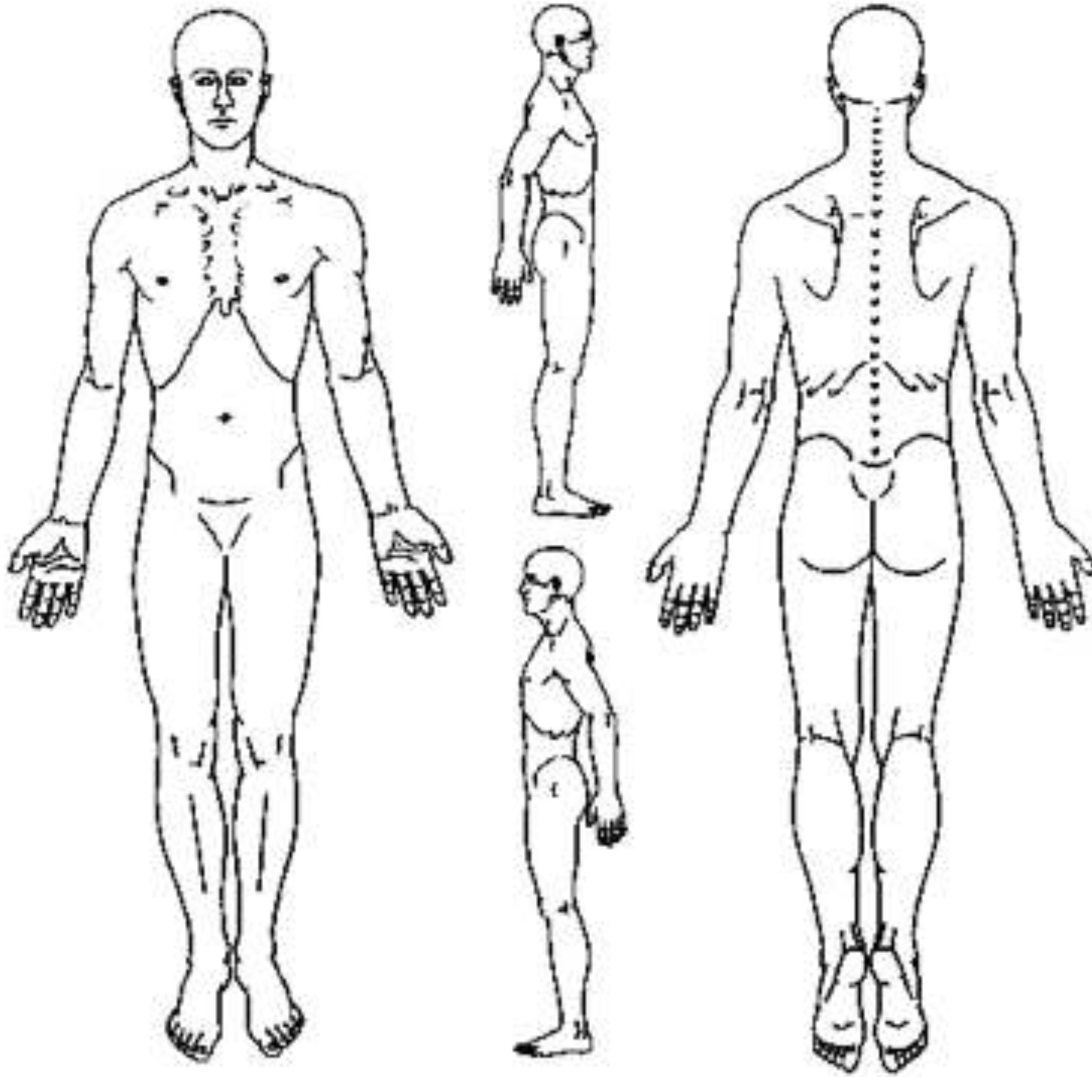
Areas with the most pain:

1. ______________________________
2. ______________________________
3. ______________________________

Does this pain interfere with: ☐Daily Routine ☐Recreation ☐Sleep ☐Work

Painful movements: ☐Bending ☐Lying down ☐Sitting ☐Standing ☐Walking

Pain Diagram (please mark all areas of pain on diagram below)
A= aching B= burning N=numbness P= pins and needles S= stabbing pain O= other



HIPAA NOTICE

Privacy Disclosure and Policies

As a patient at this clinic, you have the right to know how your private, confidential healthcare and personal information is being protected. Below are the methods in which your information is secured confidentially in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). This notice describes the policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

Safeguards in place include:
Limited access to facilities where information is stored.
Policies and procedures for handling information.
Requirements for third parties to contractually comply with privacy laws.
All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Public Interaction
Should we see you socially, by coincidence or intent, we will not acknowledge how we are acquainted unless you infer consent through introduction, etc. It is our preference to discuss your health in the office setting only to protect you privacy and ensure that important information is kept in your chart.

Consultations
We consult with other healthcare practitioners and clinical specialists while working on patient cases and treatment plans. These conversations and transfers of information by phone, in person, by fax, or email are confidential, and names are not used unless necessary and consent is provided from you either verbally or in writing. In administering your health care, we may gather and maintain information that may include these examples of non-public personal information:

From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.

From health care providers, insurance companies, workman's comp and your employer, and other third party administrators (e.g. requests for medical records, claim payment information).

Records Release
Your confidential healthcare information is private and cannot be copied and shared with anyone else without your written, signed consent. In some cases, if time does not permit, your verbal approval may be accepted after proper identification is acquired. Copies of released records are sent by mail or fax, and are accompanied by a Confidential Patient Information Cover Sheet if faxed.

Definition and Penalties to Comply
Protected health information is any information, whether oral or recorded, in any form or medium that: 1) is created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school or university, or healthcare clearing house in the normal course of business, and 2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual. This information may reside in any medium: tape, paper, disc, fax, email, and/or digital voice message.
I have read and understand my right to privacy, as stated above, and agree to have Willow Tree Wellness Clinic maintain my records confidentially in accordance with the law. I agree to inform Willow Tree Wellness Clinic if I need any special arrangements pertaining to this issue.

signature	date
print name	

INFORMED CONSENT TO RECEIVE TREATMENT

By signing below, I do hereby request and voluntarily consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named above and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

I understand that acupuncturists practicing in the state of Oregon are not primary care providers and that regular primary care by a licensed physician is recommended by this clinic's practitioners. I understand that methods of treatment may include, but are not limited to, acupuncture, Moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling.

Acupuncture: This is a safe treatment involving the insertion of fine sterile and single use needles through the skin. Treatments can occasionally produce a mild but temporary discomfort, usually achiness, tingling or soreness at the acupuncture site. Treatments can also cause slight bleeding and will rarely leave a non-painful bruise at the acupuncture site. Other possible risks from acupuncture include dizziness and fainting. I agree to come to each session having eaten within the past 3 hours, and I will report to my Licensed Acupuncturist any dizziness or light-headedness that occurs during or after an acupuncture treatment. Extremely rare risks of acupuncture include nerve damage, organ puncture and infection. These risks have an extremely low incidence, especially when acupuncture is administered properly by a Licensed Acupuncturist.

Traditional Chinese Herbal Medicine Treatments: Chinese herbs have been used safely for centuries. Infrequently, one may experience digestive upset or other reactions to herbs. If I experience any discomforts related to the use of any herbs I am prescribed, I understand that I should stop the herbs and that I am responsible for informing my Licensed Acupuncturist of my symptoms. Some herbs may be inappropriate during pregnancy or breastfeeding. I accept full responsibility to inform my practitioner immediately if I am pregnant or breastfeeding, or if I am attempting or suspecting pregnancy. With all herbal treatment, I agree to follow the prescribed dosage and administration guidelines given to me by my acupuncturist. I will inform my practitioner if I am taking any medications, or if there are any changes in my medications, before any herbal treatment is initiated.

Heat Treatments with Moxa or a TDP Lamp: These methods are used to warm areas of the body to promote health. Every precaution is taken to prevent over-warming, but the rare possibility of mild burns exists.

Cupping: This technique involves a localized suction produced by heating a small glass cup. There is a possibility of local non-painful bruising from this suction. Very rarely a slight burn or blister may appear due to the heat.

Gua Sha: Gua Sha is light scraping on the skin in a small area using a smooth-edged instrument. This often results in bruising of the treated area. The bruising, which is not painful, usually resolves in 3-7 days.

Electro-Acupuncture: A mild electric micro-current similar to a TENS treatment may be used to stimulate the acupuncture points. A mild tingling or tapping sensation will be felt during treatments. Occasionally a mild achiness or soreness will be felt at the areas treated for up to a day after the treatment. I understand that I must inform my practitioner if I am using a pace-maker or have any heart or neurological condition prior to having this treatment.

Acupressure and Massage: Acupressure and massage are used to reduce or prevent pain, and to normalize the body's physiological functions. I will inform my Licensed Acupuncturist of any areas of injury or extreme discomfort, as well as any areas where I have had surgery, prior to any massage. I understand that there may be muscle soreness or achiness as well as the possible aggravation of symptoms existing prior to the treatment during or after massage.

I understand the clinical and administrative staff may review my patient records and lab records but all my records will be kept confidential and will not be released without my written consent. By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present conditions and for any future condition(s) for which I seek treatment.

Patients who are pregnant, have a pacemaker or heart condition, have a seizure disorder, or those with a bleeding disorder or taking blood thinners should discuss this with the acupuncturist before proceeding with acupuncture.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

signature	date
print name	

PATIENT FINANCIAL POLICIES

As our patient, you are ultimately responsible for payment for all treatment and care you receive from Willow Tree Wellness. We will verify your insurance coverage as a courtesy, but knowing your insurance benefits is your responsibility, so please contact your insurance company with any questions you may have regarding your coverage. Initial ______

Willow Tree Wellness can bill as a preferred provider with most of the major insurance companies, and will submit the claims directly for those insurers only. We can also provide a Superbill with the proper codes for you to submit for reimbursement by your insurance carrier who may have acupuncture benefits.

If your visit will not be covered by an insurance plan, payment in full is expected at each visit. Willow Tree Wellness practitioners request payment for your treatment at the time of service. Cash or check payments are preferred but we also take all major credit cards.

Co-Payments, Co-Insurance and Deductibles. All co-payments, co-insurance and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. In the event we bill your insurance carrier and the claim is returned to us because the deductible has not been satisfied, we will bill you for those services. Please understand that it could take several months between the time of service and the issuing of our billing statement once we receive notification from your insurance carrier regarding your deductible balance. Initial______

Non-Covered Services. Please be aware that some, and perhaps all, of the services you receive may not be covered or considered reasonable or customary by insurance carriers. These services must be paid for at the time of your visit. In the event we bill your insurance carrier and the claim is returned to us because the services are not covered, we will bill you for the non-covered services. In addition, supplements and herbal medicine is not covered by your insurance plan. Initial ______

Insurance Claim Submission. Your insurance company may on occasion ask you to provide them with additional information. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. Please be aware that Oregon Law requires insurance claims to be paid within 30 days of submission. If they do not comply after 30 days, this balance will be billed to you. Initial ______

Returned Checks. If your check is returned for insufficient funds, there will be a $25.00 Returned Check fee added to your account, in addition to the amount the check was for. Recovery of funds is automated through our bank's FARS /ECR service, which collects promised monies on our behalf. Initial ______

Nonpayment. There is a $5.00 per month rebilling charge for all accounts carried over 30 days (this does not apply to the portion owed by your insurance). If your account is over 90 days past due from our first billing sent to you, it will be referred to an outside collection agency for payment with an additional 12% collections charge added. By signing this agreement you will also authorize the office to release information needed to secure payment. To avoid billing fees, please arrange a payment plan with Willow Tree Wellness Clinic. We want to work with our patients and understand that sometimes to pay a large balance, it may need to be broken into several payments. Initial ______

Missed Appointments. If you miss your appointment without notice or cancel with less than 24 hours notice, you will incur a $50 cancellation fee per appointment after the second occurrence. Please note that your insurance company does not pay for missed appointment; this fee is patient responsibility. Your time is reserved just for you. Last minute cancellations prevent someone else from receiving care. Initial _______

I have read and understand the policies and agree to abide by the guidelines.

_____________________________________ _____________________

Signature of patient or responsible party Date

____

Print Name

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

AUTO INSURANCE POLICY INFORMATION

Medical, Auto and Workers Comp Insurance companies recognize the effectiveness of acupuncture treatment. Acupuncture is covered by more insurance companies each year, and we are in-network with most major insurance companies. In the state of Oregon, acupuncture is covered by auto and workers comp insurance.

Please call your insurance agent to verify that acupuncture is a covered benefit. Once confirmed, we will need all of the following information to submit claims.

*Unfortunately we cannot bill the other driver's insurance regardless of who is at fault.

Auto Insurance Company ______________________________________ Phone __________________________________

Auto Insurance Policy Number ____

Claim Number ____ Date of Accident ___________________________

Medical Claims Adjuster Name____ Direct Phone______________________

Claim Address ____ City, State, Zip________________________________

Claim Fax Number ____

Active Open Benefit Y N

Medical/Acupuncture Benefit Y N

Was the accident located in Oregon? Y N

Which state is your auto insurance policy in? ____

Pain Disability Index **Patient Name**____

This questionnaire has been designed to give the practitioner information as to how your pain has affected your ability to manage in everyday life. Please answer every section and circle only ONE box the best applies to you.

TOTAL Front & Back ____________________

0 – 14	No Disability
15 – 29	Mild Disability
30 – 44	Moderate Disability
45 – 59	Severe Disability
>60	Complete Disability

Section 1 – Pain Intensity

0. I have no pain at the moment.
1. The pain is very mild at the moment.
2. The pain is moderate at the moment.
3. The pain is fairly severe at the moment.
4. The pain is very severe at the moment.
5. The pain is the worst imaginable at the moment.

Section 2 – Personal Care (Washing, Dressing, etc)

0. I can look after myself normally without causing extra pain.
1. I can look after myself normally but it causes extra pain.
2. It is painful to look after myself and I am slow and careful.
3. I need some help but manage most of my personal care.
4. I need help every day in most aspects of self-care.
5. I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are positioned higher, i.e. on a table.
3. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
4. I can lift very light weights.
5. I cannot lift or carry anything at all.

Section 4 – Reading

0. I can read with no pain in my neck.
1. I can read with slight pain in my neck.
2. I can read with moderate pain in my neck.
3. I cannot read as much as I want because of moderate pain in my neck.
4. I can hardly read at all because of severe pain in my neck.
5. I cannot read at all.

Section 5 – Headaches

0. I have no headaches at all.
1. I have slight headaches that come infrequently.
2. I have moderate headaches that come infrequently.
3. I have moderate headaches, which come frequently.
4. I have severe headaches, which come frequently.
5. I have headaches almost all the time.

Section 6 – Concentration

0. I can concentrate fully when I want to with no difficulty.
1. I can concentrate fully when I want to with slight difficulty.
2. I have a fair degree of difficulty in concentrating when I want to.
3. I have a lot of difficulty in concentrating when I want to.
4. I have a great deal of difficulty in concentrating when I want to.
5. I cannot concentrate at all.

Section 7 – Work

0. I can do as much work as I want to.
1. I can do my usual work, but no more.
2. I can do most of my usual work, but no more.
3. I cannot do my usual work.
4. I can hardly do any work at all.
5. I cannot do any work at all.

Section 8 – Driving

0. I can drive my car without any neck pain.

(OVER)

1. I can drive my car with slight neck pain.
2. I can drive my car with moderate neck pain.
3. I cannot drive my car as long as I want because of moderate neck pain.
4. I can hardly drive at all because of severe pain in my neck.
5. I cannot drive my car at all.

Section 9 – Sleeping
0. I have no trouble sleeping.
1. My sleep is slightly disturbed (<1 hour sleepless).
2. My sleep is mildly disturbed (1-2 hours sleepless).
3. My sleep is moderately disturbed (2-3 hours sleepless).
4. My sleep is greatly disturbed (3-5 hours sleepless).
5. My sleep is completely disturbed (>5 hours sleepless).

Section 10 – Recreation
0. I am able to engage in all my recreation activities with no neck pain at all.
1. I am able to engage in all my recreation activities with some neck pain.
2. I am able to engage in most, but not all, of my usual recreation activities because of neck pain.
3. I am able to engage in a few of my usual recreation activities because of neck pain.
4. I can hardly do any recreation activities because of neck pain.
5. I cannot do any recreation activities at all.

Section 11 – Walking
0. I have no pain on walking.
1. I have some pain on walking but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than 1/2 mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

Section 12 – Sitting
0. I can sit in any chair as long as I like.
1. I can sit only in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

Section 13 – Social Life
0. My social life is normal and gives me no pain.
1. My social life is normal but it increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

Section 14 – Standing
0. I can stand as long as I want without pain.
1. I have some pain on standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases the pain immediately.

Section 15 – Traveling
0. I get no pain when traveling.
1. I get some pain when traveling but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
3. I get extra pain while traveling which compels to seek alternative forms of travel.
4. Pain restricts me to short necessary journeys under ½ hour.
5. Pain restricts all forms of travel.