

Auto Accident Patient Form

PERSONAL INFORMATION/INFORMACION PERSONAL

Name/Nombre: _____

Last Name/Apellido

First Name/Primer Nombre

Address/Dirección: _____

Apt.#: _____

City/Ciudad: _____ State/Estado: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____

DOB/Fecha de Nacimiento: ____/____/____

() Single/Soltero, () Married/Casado, () Divorce/Divorciado, () Widowed/Viudo

SS#: _____ () Female/Mujer () Male/Hombre

Whom May We Notify in Case of Emergency? / Contacto de emergencia?

Relationship/Relación: _____ Tel.Number: _____

ATTORNEYS INFORMATION / ABOGADO

Attorney name/ Nombre de Abogado: _____

Phone/Telefono: _____

Address/Dirección : _____

Paralegal's Name/Nombre de Paralegal: _____

Insurance (Please provide Your Car Insurance information) Seguro de Auto:

INSURANCE INFORMATION

Your Car insurance Name? Compañía de Seguro: _____

Insured's Name/Nombre del Asegurado: _____ Relationship/Relación:

Policy/Poliza# : _____

Claim#/ # de Reclamo: _____

Phone/Telefono# : _____

EMPLOYER / EMPLEADOR

Company Name/Compania: _____

Occupation/Ocupacion: _____

Address/Direccion : _____

Phone/Telefono: _____

Have you lost days of work / Ha perdido dias de trabajo : () Yes/Si , () No if so,

When/Cuando: _____

List any Doctors seen for this matter/Indique doctores que has visto por el dolor:

ACCIDENT INFORMATION / INFORMACION DE ACCIDENTE

Date & time of Accident/Fecha Y tiempo de accidente: _____

Location/Locacion: _____

Police report/reporte Policial? () Yes/Si () No

Where were you seated/Donde estaba sentado :

- () Driver/chofer,
- () Front Passenger/pasajero,
- () Rear Passenger/pasajero de atras,
- () Pedestrian/peaton

What type of vechile were you in?/En que tipo de vehiculo estaba?

- () Compact car/Auto Compacto, () Mid size car/Auto mediano, () Full size/Auto Grande,
- () Sm. Sport Utility/Auto Deportivo Pequeno, () Lg. sport utility/auto deportivo grande,
- () Motorcycle/moto, () Motor home/Casa mobile,
- () Bicycle/Bicicleta

Type of seat belt/Que tipo de cinturon tenia?

- () shoulder and lap/ De hombro y cintura, () Lap/cintura, () Shoulder/Hombro,
- () None/Ninguno

Did the airbags deploy/Se exploto la bolsa de aire? () Yes/Si, () No

What was your vehicle doing just prior to the accident/ Como se encontraba el vehiculo en el momento del accidente:

- () Stopped at a red light, Detenido en una luz roja, () Slowing down to a stop/ Preparandose para detenerse,
- () At a complete stop, Detenido en un Stop completamente, () Merging into Traffic, Uniendose al trafico
- () Changing lanes/ Cambiando lineas

Where were you hit? /Donde fue el impacto?

- ()Rear/Atras, ()Front/Adelante,
()Driver side/A el lado de el chofer, ()Passenger side/A el lado del pasajero

Where were you looking/Adonde mirabas al tiempo del impacto?

- ()Straight ahead/Directo hacia adelante, () Left/Izquierda, ()Right/Derecha, ()Down/Hacia abajo , ()Up/hacia arriba

Where were you thrown? / Hacia donde fue aventado?

- () Forward/Hacia adelante, ()Backward/Hacia atras), ()Side to side/Para los dos lados

Did you strike against something within the vehicle? /Se golpeo contra algo dentro de el vehiculo?

- ()Dashboard/Tablero, ()Steering Wheel/Volante , ()Windshield/Parabrisas,
()Door/Puerta, ()Head Rest/Cabecera, (other)_____

Did the Airbags deploy? Se exploto la bolsa de aire? ()Yes/Si, () No

Did you have any ?/Tiene alguna ?

- ()Cuts/Cortada, () Bruise/Moretones, ()Scrapes/Raspones

Where you unconscious at the scene of the accident? Perdio ud el conocimiento en el momento de el accidente? ()Yes/Si , ()No

Where did you go after the accident?/Donde fue ud despues de el accidente?

- ()Hospital, ()Home/Casa , (Other/Otro)_____

What was done at the hospital/Que le hicieron en el Hospital?

- () X-rays/Radiografia, ()Medication/Medicamento, (Other/Otro)_____

What is the name of the doctor who treated you? /Como se llama el doctor que lo atendio?

Check the pain you have now after the accident/?

- | | |
|---|---|
| ___ Headache/Dolor de cabeza | ___ Chest pain/ Dolor de pecho |
| ___ Knee pain/Dolor rodilla (R / L) | ___ Face/Scalp pain, Dolorrostro |
| ___ Abdominal pain/Dolor Abdominal | ___ Ankle pain/Dolor talon (R / L) |
| ___ Neck & Upper Back pain/
Dolor cuello /espalsa alta | ___ Ribs pain dolor Costillas |
| ___ Shoulder pain/ Dolor Hombro(R/L) | ___ Mid-Back pain/ Dolor espalda media |
| ___ Lower Back pain
Dolor espalda baja | ___ Elbow pain/ Dolor Codo(R / L) |
| ___ Pain&Tingling on arm(R / L)
Dolor / Adormecimiento brazo | ___ Wrist pain/ Dolor Muneca(R /L) |
| ___ Hand pain/ Dolor mano (R / L) | ___ Foot pain/Dolor Pie (R / L) |
| | ___ Pain & Tingling on leg(R / L)
Dolor/ Adormecimiento pierna |

Check the Symptoms you experienced? Indique lo que sintio ?

- | | |
|---|--|
| <input type="checkbox"/> Restlessness/Inquietud | <input type="checkbox"/> Difficult concentrating/Dificultad de concentracion |
| <input type="checkbox"/> Sleeplessness/no puede dormir | <input type="checkbox"/> Dizziness/mareo |
| <input type="checkbox"/> Wobbling/Oscilacion | <input type="checkbox"/> Shortness of breath/ Falta de aliento |
| <input type="checkbox"/> Anxiety / Ansiedad | <input type="checkbox"/> Fatigued /Fatiga |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Fainting/ Desmayo |
| <input type="checkbox"/> Blurred vision/vision borrosa | <input type="checkbox"/> Constipation/ Constipacion |
| <input type="checkbox"/> Diarrhea / Diarrea | <input type="checkbox"/> Nervousness / Nerviosism |
| <input type="checkbox"/> Forgetfulness/Se olvida cosas | <input type="checkbox"/> Depression / Depresion |
| <input type="checkbox"/> Vomiting/ Vomito | <input type="checkbox"/> Double Vison/ Vision doble |
| <input type="checkbox"/> IrritabilityIrritable | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Disorientation /Desorientacion | <input type="checkbox"/> Dizziness/Mareo |
| <input type="checkbox"/> Difficulty with memory / Dificultad con la memoria | |
| <input type="checkbox"/> Trouble controlling emotions/Dificultad en controlar sus emociones | |
| <input type="checkbox"/> Ringing Ear (R / L)/ Silvido en los oidos | |
| <input type="checkbox"/> Trouble parking the car/Problema para estacionar el auto | |

Where did you feel pain immediately after the accident? Donde sintio dolor inmediatamente despues del accidente?

List your complaints, starting with the most severe/Indique sus quejas, empice por lo mas grave.

- | | |
|----------|-----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |
| 7. _____ | 8. _____ |
| 9. _____ | 10. _____ |

What aggravates the pain? / Que empeora el dolor?

- Walking / Caminar Standing / Estar parado
 Lifting / Levantar algo Turning/ Voltear
 Lying Down/Estar Acostado Sitting Down / Estar Sentado
 Working/Trabajar Bending/Agacharse

What make you feel better? / Que ayuda a mejorar su dolor?

- Medication / Medicamento Ice pack / Bolsa de hielo Rest/Descansar
 Hot Showers / Banos calientes Bed rest / Descanso total

PAST HISTORY / HISTORIAL

Where you ever involved in another car accident?/Ha estado en otro accidente de carro en el pasado?

()Yes/Si , ()No

If yes, When /Si contesto si, cuando? _____

Body Injured/Cuerpo Herido? _____

Do you have any metal / plastic / implants / pacemaker in your body Tiene algun implante de metal/plastico/ marcapasos en tu cuerpo? ()Yes , () No

If yes, Where/ Si responde si, cuando? _____

FAMILY / HISTORIAL FAMILIAR

Mother / Madre : Good health (Buena Salud) Poor Health(Mal estado de Salud)
 Cause of death (Causa de Muerte)

Father / Padre : Good health (Buena Salud) Poor Health(Mal estado de Salud)
 Cause of death (Causa de Muerte)

Agreement

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. Should it be necessary to take action to collect any amount owing under this agreement. I will be responsible for all attorneys, collection fees and any other cost in incurred in collecting the amount owed.

Certifico que he leído y entendido la información anterior a mi leal saber y entender. Las preguntas anteriores han sido respondidas con precisión. Entiendo que proporcionar información incorrecta puede ser peligroso para mi salud. En caso de que sea necesario tomar medidas para cobrar cualquier cantidad adeudada en virtud de este acuerdo. Seré responsable de todos los abogados, honorarios de cobro y cualquier otro costo incurrido para cobrar el monto adeudado.

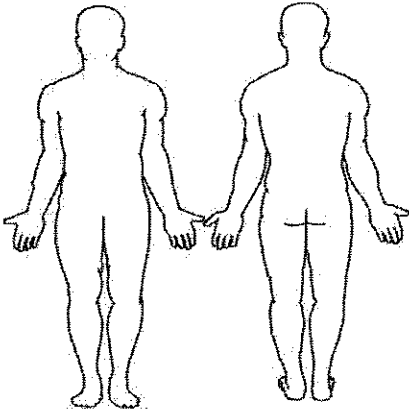
Patient Signature: _____

Date: _____

Firma del Paciente:

Fecha:

4. Mark (x) on the picture where you currently feel pain, En que lugar siente dolor?



5. Progression/ Progreso

Pain is getting Worse Better Same
El dolor siente Peor Mejor Igual

6. Duration and Timing/ Duracion

Constant Comes and goes
Constante Va y viene

How often/ Que tan seguido?

7. Aggravating Factors (what makes it worse/ que le hace sentirse peor? Such as movements Movimientos, certain activities/ algunas actividades, time of day/momento del dia, etc.)

8. Relieving Factors (what makes it better/ que le ayuda a sentirse mejor?)

9. Prior Interventions / Intervenciones Previas:

What have you done to relieve the symptoms?
Que ha intentado hacer para aliviar las molestias?

Prescription medication/Prescripcion medica

Surgery/ Cirugia

Over-the-counter drugs/ Medicinas

Acupuncture / Acupuntura

Physical Therapy Terapia Fisica

Massage

Ice

Heat

Chiropractic

Other: _____

Signature: _____ **Date:** _____

QUADRUPLE VISUAL ANALOGUE SCALE

INSTRUCTIONS: Please circle the number that best describes the question being asked.

INSTRUCCIONES: Por favor encierre el numero que mejor describa la pregunta.

NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint.

NOTA: Si ud. Tiene mas de una molestia por favor responda cada pregunta por cada molestia individualmente e indique el valor para cada uno.

EXAMPLE/ EJEMPLO:

Headache/Cabeza Neck/Cuello Low Back/ Espalda baja

0 1 (2) 3 (4) 5 6 7 8 (9) 10

1. What is your pain RIGHT NOW / Cual es su dolor EN ESTE MOMENTO?

0 1 2 3 4 5 6 7 8 9 10

2. What is your TYPICAL or AVERAGE pain / Cual es su dolor TIPICO o PROMEDIO?

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)
Cual es el nivel de dolor CUANDO SE SIENTE MEJOR (Que tan cerca de 0 llega cuando esta mas aliviado?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its best? _____ %
Que porcentaje en horas en la manana es su mejor estado de dolor?

4. What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?
Cual es el nivel de dolor EN EL PEOR MOMENTO (que tan cerca de "10" es su dolor cuando es el peor)

0 1 2 3 4 5 6 7 8 9 10

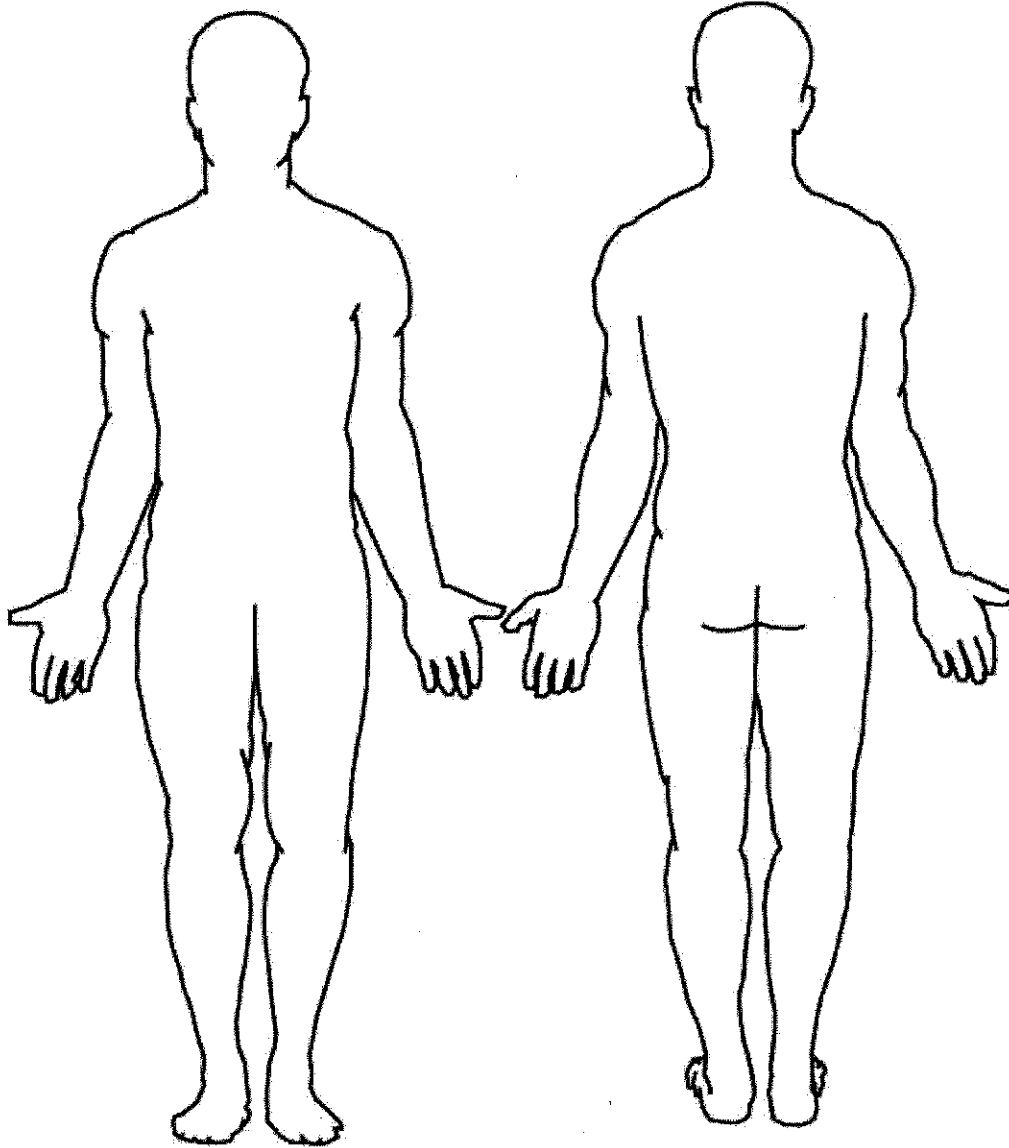
What percentage of your awake hours is your pain at its worst? _____ %
Que porcentaje es en las horas de la manana su peor dolor?

Name: _____ Account: _____ Date: _____

FRONT/FRENTE

Mark an (x) on the diagram where you feel pain
Marque una (x) donde usted siente el dolor

BACK/ ESPALDA



What does the pain feel like? Stiffness Tingling Aching
 Burning Numbness Stabbing

Como se siente el dolor? Endurecimiento Adolorido Endormecido
 Cosquilleo Ardor Punzando

Assignment and Authorization Lien

From: Yousefi Chiropractic Clinics
Ashburn Chiropractic & Rehab Center
44121 Harry Byrd Hwy Suite 125
Ashburn, VA 20147
Tel: (703) 723-0000 Fax: (703) 723-0058

Attorney: _____

Patient's Name: _____
Date of Accident: _____

I do hereby authorize the above to furnish you, my attorney will a full report of this examination, diagnosis, prognosis, etc., of myself regarding the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to the **Yousefi Clinics/ Ashburn Chiropractic & Rehab 44121 Harry Byrd Hwy Suite 125 Ashburn, VA 20147**, Such sums may be due and owed for medical services rendered to me both by reason of this accident that taken place on _____ and by reasons of any other bills that are due and to withhold such sums from any settlement, judgment or verdict as may be verdict which may be paid to you, my attorney or myself as the results of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to pay Ashburn Chiropractic & Rehab for all medical bill submitted by this clinic for services rendered to me and that this agreement so is made solely of said **Ashburn Chiropractic & Rehab** additional protection and in consideration of there is a waiting of payments. And I also understand that such payment is not contingent on any settlement, judgment, or verdict by which I any eventually recover paid fee.

Patient's Signature: _____ **Date:** _____

The understanding being attorney of record for the above patient does hereby agree to observe all terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor above named.

Attorney's Name: _____ **Date:** _____
Attorney's Signature: _____ **Date:** _____

Attention attorney please sign, date, and return one copy to Doctor's office at once along with a letter of representation.

HOW TO INCREASE YOUR PAYOFF AT THE SETTLEMENT

There is a simple way to increase your payoff at settlement.

- File a PIP Claim with your insurance Company
- PIP will pay your medical expenses
- At the settlement the Insurance Company of the “party at fault” will pay for “Pain and Suffering” and reimburse your medical expenses.

Therefore, using your PIP allows you to recover the compensation for medical expenses twice. And because of your “double-dip”, you will end up with more \$\$ in your pocket.

Note: Filing a PIP claim will not increase your insurance premium

HOW TO INCREASE THE VALUE OF THE “PAIN AND SUFFERING” PORTION OF YOUR SETTLEMENT

- Take pictures of any physical marks of the accident (bruises, cuts, lacerations, or bleeding) to show to your doctor.
- Follow your doctor’s instructions and treatment plan diligently.
- Keep all your appointments
- Be on time for your appointments so you can get the full benefit of treatment
- If you miss your appointment for reasons beyond your control (illness, death in the family, etc) call the clinic for physicians’ instructions for home care.

ASSIGNMENT OF PIP AND MED EXPENSES BENEFITS

To Whom It May Concern:

I hereby authorize and direct any insurance company with whom I may make a claim for PIP and/or MED-PAY/Med-Expense benefits, and/or my attorney to pay directly to Ashburn Chiropractic & Rehab (44121 Harry Byrd Hwy #125, Ashburn, VA 20147) any money that is owed to this health provider for services rendered to me.

Do NOT send PIP, Med-Pay, or Med-Expense benefits for these services to anyone other than this provider. DO NOT SEND THIS MONEY TO MY ATTORNEY OR ME(_____)

In event that any insurance company that is obligated to reimburse me for charges I incur with this health provider refuse to make such payments after demand is made by either me or this health provider, I hereby assign and transfer to this health provider any and all caused of action that I have against said insurance company, including but limited to the right to bring a lawsuit, for the failure to pay the available PIP and/or Med-Expenses benefits up to the amount of this health provider's full bill.

I authorize this health provider to bring any such cause of action either in my name or this provider's name. I further authorize this health provider to compromise, settle or otherwise resolve any such claim arising out of the insurance company's failure to pay to this health provider the full limit of available PIP OR MED-PAY Expense benefit up to the amount of its bill.

I understand that I remain personally responsible for the total amounts due to this health provider for its services. I understand that payment is due at the time of services. I understand that payment is due at the time services are rendered, and that this health provider is providing a courtesy to me by trying to have the bill paid through alternative sources. I agree that this document does not constitute any consideration for this health provider to await payment, and that payment may be demanded from me immediately upon the rendering of services.

I authorize this health provider to release any information pertinent to my case to any insurance company or attorney to facilitate the collection of my bill. I agree that this health provider be given Power of Attorney to endorse or sign my name on any and all checks for payment of my doctor bill.

Patient Name: _____ **Date:** _____

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

Ashburn Chiropractic & Rehab

I hereby authorize _____ to make payment directly to:

Ashburn Chiropractic & Rehab
44121 Harry Byrd Hwy #125
Ashburn, VA 20147
703-723-0000

The expense benefits are allowable, and otherwise payable to me under my current insurance policy toward the total charges for professional services rendered by this clinic.

I authorize this clinic to release any information pertinent to my case/injury to any insurance company, adjuster, doctor, and attorney involved in this case. I hereby release this clinic Ashburn Chiropractic & Rehab of any consequence thereof.

I understand that I am financially responsible for all charges incurred at this clinic including any and all deductible, co-payment, and co-insurance. Should it be necessary to take legal action to collect any amount owing under this agreement? I will be responsible for all attorney, collection fees, and other costs incurred in collecting the amount owed.

Print Name

Patient Signature / Guardian

Date

**Notification to Med-Pay Carrier of Patient's Request Not to Bill
Health Insurance**

Re: _____

DOA: _____

To Whom It May Concern:

_____, a patient of Ashburn Chiropractic & Rehab Center and an automobile policyholder with _____ insurance, has exercised their right under the HITECH-HIPAA Omnibus Rule of September 23, 2013 to restrict disclosure of their protected health information to their health insurance carrier, and has directed us to bill their medical expenses directly to you as the Med-Pay carrier.

In accordance with Virginia code 38.2-2201, enclosed with this letter is a signed document by _____ requesting not to bill their health insurance, and a fully executed Assignment of Benefits (AOB) authorizing _____ insurance to pay Ashburn Chiropractic & Rehab Center directly for medical expenses related to this claim.

Thanks for your cooperation in handling this claim in a timely manner. Please contact me at 703-723-0000 if you have any questions.

Sincerely,

Patient Signature

Date

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such case, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another healthcare provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specifically adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustment.

I, _____ have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I, therefore, accept chiropractic care on this basis.

(Signature)

(Date)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release: This is to certify that to the best of my knowledge I am not pregnant, and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that X-rays can be hazardous to an unborn child. **Date of last menstrual period:** _____

(Signature)

(Date)

PHYSICAL MEDICINE AND REHABILITATION SERVICES

97010 Application of a modality to one or more areas; Hot or Cold Packs: The application of heat, through the use of hot packs, also called hydrocollator packs, is often most effective in sub-acute or chronic problems. The use of hot packs is considered a superficial heat application. In general terms, the application of cold (withdrawal of thermal energy) is the treatment of choice in a patient with acute trauma or severe plasticity. This application can be in the form of ice packs; in some applications, this is also referred to as "cryotherapy"

97012 Traction; Mechanical: The force used to create a degree of tension of soft tissues and/ or to allow for separation between joint surfaces. The degree of traction is controlled through the amount of force (pounds) allowed, duration (time), and angle of pull (degrees) using mechanical means.

97014 IFC (Interferential Current/Medium Current): These units have a special carrier frequency that allows the current to go deeper into the tissues. IFC is used to control swelling and pain.

97035. Ultrasound: The use of sound waves to increase absorption of heat to a deeper penetration level. Much of the value of ultrasound is providing pain relief due to its superior depth of penetration. This modality is used in the treatment of arthritis, neuromas, and adhesive scars, and where increasing the temperature is the desired effect.

97110 Therapeutic Exercise: One or More Areas; Therapeutic Exercises to Develop Strength, and Endurance, Range of Motion, and Flexibility. Therapeutic Exercise incorporates one parameter (strength, endurance, range of motion, of flexibility) to one or more areas of the body. Examples include Kinetic Exercises (for range of motion), Lumbar stabilization exercises (flexibility), and gymnastic ball stretching/strengthening.

97140 Manual Therapy techniques: (e.g. mobilization/manipulation, manual lymphatic drainage, manual traction, myofascial release therapy)

Chiropractic Manipulative Treatment (CMT):

98940 Spinal, One to Two regions

98941 Spinal, Three to four or more regions

98943 Extraspinal, One or More regions (e.g. shoulder/knee)

By signing my name below, I acknowledge that I have read the above, had the opportunity to ask questions and that all my questions have been answered fully and satisfactorily. I have also received a copy of this form.

Print Name: _____

Signature: _____

Date: _____

Patient Pregnancy Disclaimer

This certifies that concerns regarding pregnancy and radiation exposure have been explained to my satisfaction. I understand the clinical necessity of having x-rays taken at this time and grant permission for this procedure. In doing so, I release the doctor/clinic from responsibility for potential damage arising from this procedure.

At the present time:

- I am sure I am not pregnant
- It's possible that I could be pregnant
- I am pregnant

Patient Signature: _____

Date: _____

Witness Signature: _____

Date: _____

I _____ agree to be responsible for paying my bill in full to Ashburn
Chiropractic.

I Understand that Ashburn Chiropractic may bill my health or automobile Insurances Companies
for partial payments of my Chiropractic bill as a convenience for me.

However, I remain contractually obligated to pay any portion of my bill that remains unpaid by
said insurance companies' payments.

Further, I authorize Ashburn Chiropractic to submit claims for medical payments directly to my
automobile insurance company, and that the office shall be able to retain such payments and
apply them to any outstanding balances with the office.

I agree that Ashburn Chiropractic has the right to pursue any unpaid chiropractic bills against me
in a Court of Law, and that they shall further be entitled to any collection costs, including
reasonable attorney fees should I breach my agreement to pay said chiropractic bill in full. The
forum for such disputes shall be the Courts of Loudoun County, VA.

I have carefully and fully read and agree to the terms of treatment set forth above.

Patient Name / Signature

Date

NOTICE OF PRIVACY PRACTICES

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 Practice (the "practice"), in accordance with the Federal Privacy Rule, 45 CFR parts 160 and 164 (the "Privacy Rule") and applicable state laws, is committed to maintaining the privacy of your protected health information ("PHI", PHI) Includes information about your health condition and the care treatment you received from the Practice and is often referred to as your health care of medical record. This notice explains how your PHI may be used and disclosed to third parties. This notice also details your rights regarding your PHI.

HOW THE PRACTICE MAY BE USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The Practice, In accordance with this Notice and without asking for your express consent or authorization, may use and disclose your PHI for the purposes of: (a) Treatment- To provide you with the health care you require, the Practice may use and disclose your PHI to those health care professionals, whether on the Practice's staff or not, so that it may provide, coordinate, plan and manage your health care. For example, a chiropractor treating you for lower back pain may need to know and obtain the results of your latest physician examination or last treatment plan. (b)Payment- To get paid for services provided to you, the Practice may provide your PHI, directly or through a billing service, to a third party who may be responsible for your care, including Insurance companies and health plans. If necessary, the Practice may use your PHI in other collection efforts will respect to all persons who may be liable to the Practice for bills related to your care. For example, the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice can be reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment time. (c) Health Care Operations- To operate in accordance will applicable law and Insurance requirements, and to provide quality and efficient care, the Practice may need to compile, use and disclose your PHI. For example, the Practice may use your PHI to evaluate the performance of the Practice's personnel in providing care to you.

Other EXAMPLES OF HOW THE PRACTICE MAY USE YOUR PHI: (a) Advice of Appointment and Services from time to time, contact you to provide appointment reminders. The following appointment reminders may be used: a) a postcard mailed to you at the address provided by you; and b) telephoning your home/leaving a message on your answering machine or with who answers the phone. (b) Directory/Sign-In Log- we maintain a sign-in log at its reception desk for individuals seeking care and treatment in the office. The sign-in log is located in a position where staff can readily see who is seeking care in the office, as well as the Individual's location within the Practice's office suite. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices. (c) Family/Friends - The practice may disclose to a familiar member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care. We may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply: I) If you are present at or prior to the use or disclosure of your PHI, the practice may use or disclose your PHI if you agree, or if the practice can reasonably infer from the circumstances, based on the exercises of its professional judgment, that you do not object to the use or disclosure. (II) If you are not present, the practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interest and if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

OTHER USE & DISCLOSURES WHICH MAY BE PERMITTED OR REQUIRED BY LAW

The Practice may also use and disclose your PHI without your consent or authorization in the following instances: (a)De-Identified Information- health information that may be related to your care but does not identify you and cannot be used to identify you. (b)Business Associate- The Practice may use and disclose PHI to one or more of its business associates if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payments to insurance information. 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 for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible. The Practice may also use and disclose PHI 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) Public Health Activities- when required by law to provide information to a public health authority to prevent or control disease. f) Abuse, Neglect or Domestic Violence- when authorized by law to provide information if it believes that the disclosure is necessary to prevent serious harm. g) Health Oversight Activities- We may use and disclose PHI when required by law to provide info in criminal investigations, disciplinary actions, or other activities relating to the community's health care system h) Judicial and Administrative Proceeding- in response to a court order or a lawfully issued subpoena. i)Law Enforcement Purposes- when authorized, to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena, or if the Practice believes that your death was the result of criminal conduct. i) Coroner or Medical Examiner- to a coroner or medical examiner for the purpose of identifying you or determining your cause of death. k) Organ, Eye or Tissue Donation-The Practice may use and disclose PHI if you are an organ donor to the entity to whom you have agreed to donate your organs. l) Research- The Practice may use and disclose PHI subject to applicable legal requirements if the Practice is involved in research activities. m) Avert a Threat to Health or Safety- The Practice may use and disclose PHI if it believes 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 and the disclosure is to an individual who is reasonably able to prevent or lessen the threat. n) Specialized Government Functions - when authorized by law with regard to certain military and veteran activity. o) Workers' Compensation - The Practice may use and disclose PHI if you are involved in a Workers' Compensation claim to an individual or entity that is part of the Workers' Compensation system. p) National Security and Intelligence Activities to authorized governmental officials with necessary intelligence information for national security activities. g) Military and Veterans- if you are a member of the armed forces, as required by the military command authorities. 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 or consent you have given to the Practice, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer (b) Request special restrictions on certain uses and disclosures of your PHI as authorized by law. In general, this relates to your right to request special restrictions concerning disclosures of your PHI regarding uses for treatment, payment and operational purposes under Privacy Rule, Section 164.522 (a) and restrictions related to disclosures to your family and other individuals involved in your care under Privacy Rule, Section 164.510. (b) Except in certain instances, the Practice may not be obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment. (c) Receive confidential communications or PHI by alternative means or at alternative locations as provided by Privacy Rule Section 164.522(b). For instance, you may request all written communications to you marked "Confidential Protected Health Information." You must make your request in writing to the Practice's Privacy Office. The Practice will accommodate all reasonable requests. (d) Inspect and copy your PHI as provided by federal law (including Privacy Rule, Section 164.524) and state law. To inspect and copy your PHI, you must submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request. In certain situations that are defined by law, the Practice may deny your request, but you will have the right to have the denial reviewed as set forth more fully in the written denial notice. (e) Amend your PHI as provided by federal law (including Privacy Rule, Section 164.526) and state law. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it not in writing. If you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement (f) Receive an accounting of disclosures of your PHI as provided by federal law (including Privacy Rule Section 164.528) and state law. To request an accounting, you must submit a written request to the Practice's Privacy Officer. The request must state a time period, which may not be a longer than six (6) years and may not include dates before April 14, 2013. The request should indicate in what form you want the list (such as a paper or electronic copy). The first list you request within a twelve (12) month period will be free, but the Practice may charge you for the cost of providing additional lists. The Practice will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred. (g) Received a paper copy of this Privacy Notice from the Practice (as provided by Privacy Rule Section 164.520(b)(1)(v)(F)) upon request to the Practice's Privacy Officer. (h) Complain to the Practice or to the Secretary of HHS (as provided by Privacy Rule Section 164.520(b)(1)(vi)) if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

To obtain more information about your privacy rights or if you have questions you want answered about your privacy rights (as provided by Privacy Rule Section 164.520(b)(2)(vii)), you may contact the Practice's Privacy Officer as follows: Name: Mohammad Yousefi at 9200 Colesville Road Silver Spring, MD 20910 Phone#: 301-585-3200

PRACTICE'S REQUIREMENTS

(a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI. (b) Under the Privacy Rule, may be required by State Law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law. (c) The Practice 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 your PHI that it maintains. (e) Will distribute any revised Privacy Notice to you prior to implementation (f) Will not retaliate against you for filing a complaint. Effective Date This Notice is in effect as of 04/15/2013.

PATIENT ACKNOWLEDGEMENT By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Print Name

Signature Patient/Guardian

Date



Ashburn Chiropractic & Rehab

INJURED?

WHY HIRING A LAWYER?

Accidents happen every day in our area and in many cases, people are injured when they did not even cause the accident. Being in that situation can be frightening and overwhelming. Insurance companies almost immediately call to ask for statements and, in many cases, offer unsolicited, or even give incorrect advice. At the same time, victims are often concerned about their injuries, missing work, their car, and other damages. Unfortunately, these factors leave victims feeling compelled to give recorded statements and sign documents they do not understand, which can affect their rights and ability to seek fair compensation for their claims.

• I CAN JUST HANDLE MY CLAIM MYSELF, RIGHT?

NO, Insurance companies often undervalue of your claim or refuse to pay them altogether. In the past, some accident victims with very minor injuries often would handle their own claims, however, the current environment makes a negative and costly experience more likely for an unrepresented accident victim with personal injury claims.

• ISN'T MY INSURANCE SUPPOSED TO PROTECT ME?

NO, unless you have FULL COVERAGE to pay for your car repairs and PIP/MEDPAY to pay your medical bills, your insurer may not be there to help you when you are in an accident. Even with this coverage, sometimes your own Insurance will tell you to call the other Insurance company. If the other person at fault does not have Insurance or does not have enough Insurance to cover damages they caused, then your own Insurance company could end up working against you instead of protecting you.

• WHY DO I NEED A LAWYER?

An experienced personal injury law attorney manages these claims on a daily basis and can guide an injured person through the maze of insurance claims. Insurance companies are becoming more difficult, and you will find that having an attorney is a valuable resource in helping to resolve an accident claim. A lawyer can provide the first consultation free of charge, then manage the claim pending payment from the closing of the case and that way they do not have to give an advance, until at the end of the case if they are able to resolve the claim.

• WILL I BE PENALIZED FOR HIRING A LAWYER?

NO, hiring an attorney only assures you that someone is protecting your well-being. The agents who work the claims work for the insurance company. No matter how "NICE" or "NICE" they are, their job is to protect the insurance company – not you. There is nothing wrong with hiring a personal injury lawyer.

He / She will be there protecting her interests!