

PATIENT INTAKE FORM

Please Print Clearly

Name: _____ Social Security #: _____

Address: _____

City _____ State: _____ Zip _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail (PLEASE!): _____

Date of Birth: _____ Age: _____ Male Female

Married Widowed Single Separated Divorced Minor

Patient Employer/School: _____ Occupation: _____

Spouse's Name: _____ Date of Birth: _____

Family Medical Doctor: _____ Phone: _____

How were you referred to this office? _____

Emergency contact: _____ Phone: _____

(Name/Relation)

Please check any/all insurance coverage that may be applicable in this case:

Major Medical Workers' Compensation Medicare

Auto Accident Other _____

Name of person responsible for the insurance account: _____

Relationship to Patient: _____

Insurance Company: _____

INJURY INFORMATION

Current Symptoms/Injury: _____

Was the injury a result of : Work Slip/Fall Car Accident Chronic Other

When did your symptoms appear: _____ Specific Date Gradually/Over time

Are your symptoms: Getting Better Getting Worse Staying about the same

Have you previously seen any health care specialist for this condition: Yes No

Who did you see? _____

Are you currently working? Yes No If No, is that due to this injury? Yes No

MEDICAL HISTORY

Have you ever had the same/similar symptoms? No Yes If yes, please explain: _____

Prior treatment with: MD Chiropractor Physical Therapy Acupuncture Massage

Has any prior treatment helped? Yes No a little

Any prior surgeries? No Yes If yes, please describe: _____

Please list any health conditions that you have or have had before (cancer, heart disease, diabetes, arthritis, etc.): _____

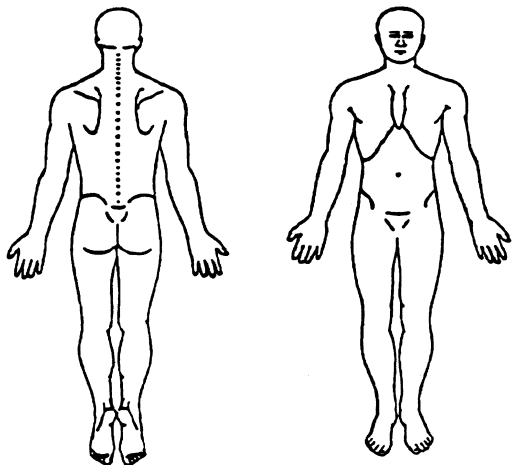
Have you ever been under the care of a Chiropractor? Yes No If Yes, for what? _____

Please list all current medications (Prescription and non-Prescription): _____

Patient Signature: _____ Date: _____

CURRENT INJURY/SYMPTOMS

1. Please mark the area(s) where your symptoms are at?



2. What percentage of time do you feel pain?
 0-25% 25-50% 50-75% 75-100%

3. Where is your pain level today?
(low) 0 1 2 3 4 5 6 7 8 9 10 (highest)
 Where is your pain level at its worst?
(low) 0 1 2 3 4 5 6 7 8 9 10 (highest)

4. What activities/movements increase your pain levels?

5. Type of Pain: Sharp Dull Throbbing Numbness Cramps
 Aching Shooting Burning Tingling Stiffness
 Swelling Other _____

6. Do you have any weakness in your arms or legs? Yes No

7. Have you been told that your current injury requires surgery? Yes No

OTHER SYMPTOMS

Do you have ANY of the following symptoms?

Pain worse at Night **Unexplained Weight Loss** **Weakness in the Arms/Legs**
 Recent Surgery (30 Days) **Loss of Bowel or Bladder Control** **Urinary Discharge**
 Loss of Sensation **Fatigue/Loss of Energy** **Trouble with Balance/Coordination**

Does your condition interfere with; **Work** **Sleep** **Sports** **Recreation** **Normal Daily Routine**

Have you had any prior imaging studies? **X-Ray** **MRI** **CT Scan** **Bone Scan**

| | | | |
|--------------------|--|-------|--|
| Print Name: | | | |
| Patient Signature: | | Date: | |

INFORMED CONSENT
DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctors procedures often depend on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health services.

ANALYSIS

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its natural restorative powers. This depends upon the inborn recovery powers of the body.

DIAGNOSIS

Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concerns as to the nature of his/her total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic test, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctors, of course, will not give chiropractic adjustment, or health care, if he/she is aware of such care and may be contradicted. Again, it is the responsibility of the patient to make it known or to learn through health care procedure whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnosis and clinical procedures. The doctor of chiropractic provides a specialized, non-duplication health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS

The purpose of chiropractic is to promote satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions that do not respond to the chiropractic may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great stride in alleviating pain and controlling disease.

TO THE PATIENT

Please discuss any questions or problems with the doctor before signing this statement of policy.

I have read, and understand the foregoing.

Signature

Date

OFFICE POLICIES

- 1) Please be on time for your appointment. Being late or making last minute cancellations will cause scheduling disruptions, which can interfere with the quality of care you and other patients receive.
- 2) Please do not wear strong perfumes or colognes. We see many patients with allergies or respiratory problems. Strong scents can impair their progress.
- 3) Continued cancellations or missed appointments may result in being released from care. If you need to reschedule an appointment, please call within 24 hours of your scheduled appointment.
- 4) Children are welcome here as patients. If you bring children with you for your appointment, you are responsible for their actions at all times. Our staff will assist you with your well-behaved children.
- 5) We may schedule you for multiple appointments. This will help insure a convenient appointment time for you, as well as provide you with the highest level of care possible.
- 6) If you need to spend extra time discussing your health concerns with your doctor, please let our staff know so we may schedule your next appointment accordingly.
- 7) Please notify your doctor of any changes in your health status, regardless of the significance.

FINANCIAL POLICIES

- 1) We accept the following forms of payment: Cash, personal checks, debit cards, Visa and Master Card.
- 2) Payment is expected at the time of the visit.
- 3) We will bill your primary insurance company for Initial Intensive Care as a courtesy to you.
- 4) The Patient is always responsible for the payment of their care. An insurance contract is between the patient and the insurance company.
- 5) Insurance coverage is never guaranteed. If there are any problems between the insurance company and the patient, the latter may file a grievance directly with your insurance company. Your signature below authorizes assignment to this office for collection of benefits and also authorizes this office to release daily chart notes when necessary for the processing of claims.
- 6) The office manager may approve account balances. Active monthly payments are required. Accounts with balances 30 days past due may be charged a service fee of 12% per year compounded monthly.
- 7) Any account where no payment has been received for sixty days may be sent to a third party collection agency. Any additional collection fees will be the responsibility of the patient. NSF checks or rejected credit card payments will be charged a service fee of \$35 per occurrence.
- 8) We do offer a **time of service discount** when services are paid in full at the time of the visit. This discounted amount will be passed on to your insurance company.
- 9) In some cases, we may have a contract with your insurance company governing how we handle your account. This contract may prevent us from offering you our *time of service discount*. Please ask us if you have any questions regarding this.
- 10) Please feel free to ask us any financial questions you may have. Our intent is to provide you with the highest level of service as well as care.
- 11) Your insurance company determines benefits when they receive our billings. Any statements made by our staff regarding your coverage in no way guarantees that your care here will be covered by your insurance company, and you will be responsible for your account, regardless of insurance.

By signing below, I acknowledge that I understand the policies as contained herein.

Patient or guardian: _____ Date: ___/___/___

Witness: _____ Date: ___/___/___

PRIVACY STATEMENT (HIPAA GUIDELINES)
Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Essential Chiropractic for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bill or to conduct health care of Essential Chiropractic.

I understand the diagnosis of treatment of me by Essential Chiropractic may be conditioned upon my consent as evidence by my signature of this document.

I understand I have the right to request a restriction to protect my health information when used or disclosed to carry out treatment, payment or health care operations of the practice. Essential Chiropractic is not required to agree to the restriction that I may request. However, if Essential Chiropractic agrees to a restriction that I request, the restriction is binding on Essential Chiropractic. I have the right to revoke this consent, in writing, at any time, except to the extent that Essential Chiropractic has taken action in reliance on this consent.

I understand I have the right to review Essential Chiropractic's Notice of Privacy Practices prior to signing this document.

The Essential Chiropractic Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operation in the (Health Care Provider).

The Notice of Privacy Practices for Essential Chiropractic is also provided at 1050 140th Avenue NE, Suite D, Bellevue, WA 98005 and on the Essential Chiropractic web site.

This Notice of Privacy Practices also describes my rights and the duties of Essential Chiropractic with respect to my protected health information.

Essential Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by accessing the Essential Chiropractic web site, calling the office, requesting a revised copy to be sent in the mail, or asking for one at the time of my next appointment.

Notice of Privacy Practices - Acknowledgment

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the Privacy Officer.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed and how you can access your information.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

Signature

Date