CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Cell Phone (_____) _____ Home Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

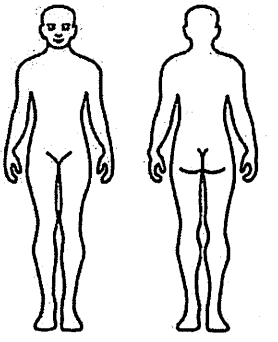
5 PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

6 HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No		
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	Other _____	
Chicken Pox	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
				Rheumatoid Arthritis	☐ Yes ☐ No		

EXERCISE
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS
- ☐ Smoking — Packs/Day _____
- ☐ Alcohol — Drinks/Week _____
- ☐ Coffee/Caffeine Drinks — Cups/Day _____
- ☐ High Stress Level — Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

7 MEDICATIONS

_____

_____

_____

Pharmacy Name _____

Pharmacy Phone (____) _____

ALLERGIES

VITAMINS/HERBS/MINERALS

Family Health History

Please "X" mark the following that your family has experience in the past:

- o AIDS/HIV
- o Alcoholism
- o Anemia
- o Anorexia
- o Appendicitis
- o Arthritis (what type and where)? _____
- o Asthma
- o Bleeding Disorders
- o Breast Lump (Please Explain _____
- o Bronchitis
- o Bulimia
- o Cancer (What type and where)? _____
- o Chemical Dependency
- o Diabetes
- o Depression
- o Emphysema
- o Epilepsy
- o Fractures (Where and how)?
- o Heart Disease
- o Hepatitis
- o Hernia
- o Herniated Disc (what level and How did this occur)?_____
- o High Cholesterol
- o Kidney Disease
- o Liver Disease
- o Migraine Headaches
- o Multiple Sclerosis
- o Osteoporosis
- o Pace Maker
- o Parkinson's disease
- o Pinched Nerve
- o Pneumonia
- o Polio
- o Prostate Problems
- o Psychiatric Care
- o Rheumatoid Arthritis
- o Stroke
- o Thyroid Problems
- o Tumor (Please detail :_____)
- o Ulcers
- o Whiplash (When? _____)
- o Previous Chiropractic Care: Last date of treatment _____

By Whom? _____

For What? _____

_____ _____

Patient Signature Date

612 SW 152nd St * Burien *Washington *98166 * Ph :(206) 244-1466 * Fax :(206) 246-4636

Burien Spine & Sport Rehab
612 SW 152nd St
Burien WA 98166
Ph: (206) 244-1466 **F: (206) 246-4636**

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. 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. You have the right, as a patient, to be informed about the condition of your health and recommended care and treatment to be provided so that you may make the decision whether or not to under go chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is science and art, which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. **Health** is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a **vertebral subluxation.** This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alterations of the nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment.** An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual finding, we will advise you of these findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternative of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on basis.

_____ _____

Patient Name Signature

Consent to evaluate and adjust a minor:

I, _____ being the parent or legal guardian of_____ have read and fully understand the above Informed Consent 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-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

_____ _____

Signature Date

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FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to the successful completion of your treatment. We ask you to understand that payment of your bill is considered a part of your treatment. This statement of our financial policy must be read and signed prior to beginning treatment.

PATIENTS WITH INSURANCE COVERAGE

We are contracted with a number of insurance plans, including Medicare, Regence Blue Shield, Premera Blue Cross, Aetna, First Choice, United Health Care, and the Department of Labor & Industries. As part of those contracts, we submit the billing and accept assignment of benefits. You will be required to make your co-pay at each visit, or you account will be charge a $25 billing fee. Any balance remaining as your responsibility after insurance has paid should be remitted to us when you receive your Explanation of Benefits from your carrier. Some, and perhaps all, chiropractic services may not be covered by your insurance, and you will responsible for payment of those charges in full. It is your responsibility to know and understand what your chiropractic benefit is. In the event that we are not contracted with your plan, you will be expected to pay cash at the time of service, although we are happy to submit the billing on your behalf.

PATIENTS WITHOUT INSURANCE COVERAGE

Patients who have no insurance coverage are expected to pay in full at the time of service. We accept cash and checks, as well as VISA and MasterCard if you prefer to pay by credit card. Charges to a credit or debit card that are declined will be the responsibility of the patient to pay in cash.

MINOR PATIENTS

We are unable to see unaccompanied minor patients unless the services have been pre-authorized in advance by a parent or legal guardian. Payment policies apply as outlined above.

MISSED APPOINTMENTS

You must cancel your appointment at least 24 hours in advance to avoid a fee for a missed appointment.

INTEREST CHARGES

We reserve the right to assess a 1% interest charge per month on accounts in which there has been no payment activity for over one month.

NSF CHECKS

A $25 fee will be charged for any check returned due to insufficient funds.

PAYMENT PLANS

In certain cases, we may agree to carry a balance for you. We will ask that you give us a credit card imprint to secure the account, and if we do not receive your payment as scheduled we will charge that credit card for your payment.

COLLECTION

In the event that your account is placed with a collection agency, you will be responsible for payment of any and all collection fees and reasonable attorney fees and court costs that may result. A lien may be placed to secure payment from all parties.

Please let us know if you have questions or concerns about the above.

STATEMENT OF FEES

The following is a list of some, but not all, services and fees:

Examinations	
Initial exam	$60.00 - $200.00
Comprehensive initial exam	$250.00 - $300.00
Repeat Exam	$60.00 - $85.00
X-Rays	
Neck (2-3 views)	$75.00 - $125.00
Mid -Back (2 views)	$95.00
Low back (2 views)	$95.00 - $160.00
Spinal Adjustments	
Adjustments	$45.00 - $60.00
Extra Time (Cryotheraphy, Trigger Point, Therapy, etc.)	$40.00-$60.00
Massage Therapy	
One Hour Massage	$65.00 - $125.00
Half Hour Massage	$32.50-$65.00

Payment Policy

We accept Cash, Check, Visa and MasterCard

Today I will be paying by: Cash_____ Check_____ Credit_____ Insurance_____

A Twenty ($25) dollar fee will be charge for any check return for non-sufficient funds. Credit or debit charges that are denied will be billed directly to the patient for payment in cash. Reoccurring missed appointment may become subject to a service fee. In the event my account should be placed for collections, I agree to pay any and all collection fee and reasonable attorney fees and court cost that may be incurred on my behalf. A lien may be placed on placed to secure payment from all parties. All accounts without payment activity over thirty (30) days may become subject to interest charges.

Prices are subject to change without notice.

I acknowledge that I have read and understand this document and agree to abide by the contents.

_____ _____

Patient Signature Date

Burien Spine & Sport Rehab

Credit Card/HSA/FSA Authorization

Patient Name: _____

Cardholder Name: _____

Phone number: _____ (used for courtesty call before CC charged)

Card Information:

- Card Type: _____
- Card Number: _____
- Expiration Date: _____

Allowed Amount to be charged each date of service: $_____ while meeting DEDUCTIBLE

Allowed Amount to be charged each date of service: $_____ for Individual copay or co-insurance (after DEDUCTIBLE has been met)

☐ I authorize Burien Spine & Sport Rehab to hold my credit card information in my file.

I authorize Burien Spine & Sport Rehab to charge this credit card directly for my medical deductible, particular co-pay or co-insurance payment amount. I certify that I am a person who is authorized to use this credit card.

☐ I DO NOT authorize use of a card on file

Signature: _____ *Date*: _____

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations **without your authorization.** These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to

family members or those who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e., electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only an acknowledgment that you have received this Notice of our Privacy Practices:

Patient Name: _____

Signature: _____

Date: _____