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? _____

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

PHONE NUMBERS

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

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

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

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) _____

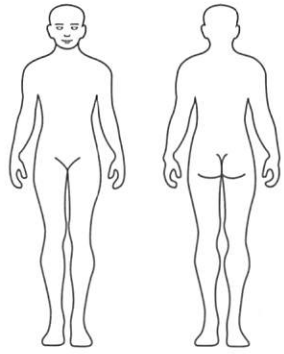
PATIENT CONDITION

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) _____

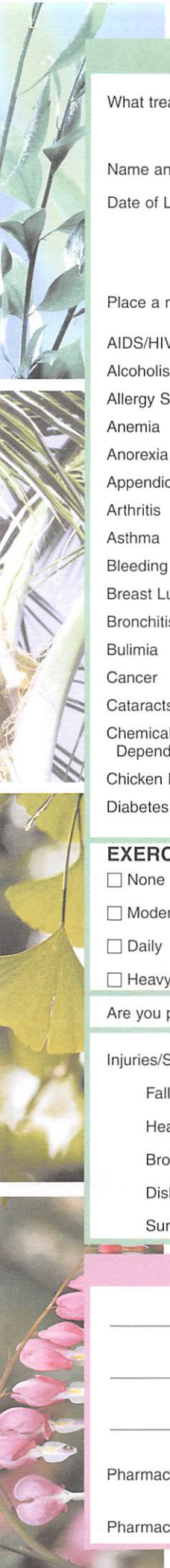
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

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



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

MEDICATIONS

_____
_____
_____

Pharmacy Name _____

Pharmacy Phone (____) _____

ALLERGIES

_____
_____
_____
_____
_____

VITAMINS/HERBS/MINERALS

_____
_____
_____
_____
_____

CHIROPRACTIC
NORTHWEST & Massage

Bus: 253-845-5358
Fax: 253-845-5753

Notice of Privacy Practices of Chiropractic Northwest

Under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), Chiropractic NW must take steps to protect the privacy of your protected health information (PHI). PHI includes information that we have created or received regarding your health or payments for your health. It includes both your medical records and personal information such as your name, social security number, address, and phone number.

Under federal law we are required to:

- Protect the privacy of your PHI. All of our employees are required to maintain the confidentiality of PHI and receive appropriate privacy training.
- Provide you with this Notice of Privacy Practices explaining our duties and practices regarding your PHI.
- Follow the practices and procedures set forth in this Notice.

Uses and disclosures of your protected health information by Chiropractic NW that do not require your authorization.
Chiropractic NW uses and discloses PHI in a number of ways connected to your treatment, payment for your care and health care operations. Some examples of how we may use or disclose your PHI without your authorization are listed below.

In relation to your health care and treatment:

- To Chiropractic NW employees involved in your care.
- To other health care providers who are not on our staff such as specialists or general practitioners.

In relation to payment:

- To administer your health benefits policy or contract.
- To bill you for health care we provide.
- To pay others who provided care to you. To other organizations and providers for payment activities unless disclosure is prohibited by law.

In relation to health care operations:

- To administer and support our business activities or those of other health care organizations (as allowed by law) including providers and plans. For example, we may use your PHI to review and improve the care you receive, to provide training, and to help decide what rates to charge.
- To other individuals (such as consultants and attorneys) and organizations that help us with our business activities. (Note: If we share your PHI with other organizations for this purpose, they must agree to protect your privacy.)

For legal and/or governmental purposes in the following circumstances:

- Required by law – when we are required to do so by state and federal law, including workers' compensation laws.
- Public health and safety – to an authorized public health authority or individual to:
  - Protect public health and safety.
  - Prevent or control disease, injury or disability.
  - Investigate or track problems with prescription drugs and medical devices.
- Abuse or neglect – to government entities authorized to receive reports regarding abuse, neglect or domestic violence.
- Oversight agencies – to health oversight agencies for certain activities such as audits, examinations, investigations, inspections and licensures.
- Legal proceedings – in the course of any legal proceeding in response to an order of a court or administrative agency and, in certain cases, in response to a subpoena, discovery request, or other lawful process.
- Law enforcement – to law enforcement officials in limited circumstances for law enforcement purposes. (To identify or locate a suspect, witness or missing person; to report a crime; or to provide information concerning victims of crimes.)
- Military activity & national security – to the military and to authorize federal officials for national security and intelligence purposes or in connection with providing protective services to the president of the United States.

Miscellaneous reasons we may disclose your PHI without your authorization:

- To a member of your family or a close friend – or any other person you identify who is directly involved in your health care – when you are either not present or unable to make a health care decision.
- To you, to remind you in writing, by phone or voice mail that you have an appointment with us.
- To communicate with you about treatment services, options, as well as health-related benefits or services that may be of interest to you.

Uses and disclosures of your protected health information that require us to obtain your authorization.
Except in the situations listed above, we will use and disclose your PHI only with your written authorization.

Your rights regarding your protected health information
You have the right to:

- Request restrictions by asking that we limit the way we use or disclose your PHI for treatment, payment or health care operations. All requests must be done in writing.
- Ask that we communicate with you by other means. For example, if you would like for us to communicate with you at a different address or phone number. All requests must be done in writing.
- Requesting a copy of your PHI. This request must be made in writing and we may charge a reasonable fee for the cost of producing and mailing the copies.
- Ask us to amend PHI about you that we use to make decisions about you. Your request for an amendment must be in writing and must provide the reason for your request.

Chiropractic Northwest, Inc. may change the terms of this Notice at any time. The revised Notice would apply to all PHI that we maintain. If we change any of the practices described above, a revised Notice will be posted.

Patient Signature: _____ Date: _____

I choose to decline receipt of my clinical summary after every visit.

_____
Patient Signature Date

Private Patient Health Insurance Verification Questionnaire

With federal mandated patient privacy in the ever-changing healthcare industry, it is no longer convenient or permissible for our office to verify your insurance benefits. We appreciate your assistance with this very important matter.

Please reference your health insurance handbook, website or phone your health insurance directly in order to accurately verify the benefits below. A "**co-pay**" is the dollar amount or percentage amount paid by you the patient. If a percentage amount is referenced in your handbook, it may also be referred to as a "**co-insurance**". *Annual Deductible is the amount paid by you personally each plan year before insurance steps in to assist.*

1. Do I have an HSA (Health Savings Account) plan? Y or N

2. Do I have an employer sponsored FSA (Flexible Spending Account)? Y or N

3. Do I have an employer sponsored HRA (Health Reimbursement Account)? Y or N

4. My Annual Deductible is $_____ and begins every (Jan., July, etc.) _____

5. Has my Annual Deductible been met? Y or N How much is remaining? $_____

6. My co-pay amount for "**spinal adjustments or manipulations**" is ($ or %) _____
Are spinal adjustments or manipulations subject to the deductible? Y or N
Is there a yearly visit limit on spinal adjustments or manipulations? _____

7. My co-pay amount for "**extremity adjustments or manipulations**" is ($ or %) _____
Are extremity adjustments subject to the deductible? Y or N
Is there a yearly visit limit on extremity adjustments? _____

8. My co-pay amount for "**massage therapy**" is ($ or %) _____
Is massage therapy subject to the deductible? Y or N Is there a yearly visit limit on massage therapy? _____ If a **Regence** plan, my in network massage therapy co-pay is ($ or %) _____ VERSUS my out of network co-pay is ($ or %) _____

9. My co-pay amount for "**office visit**" exams is ($ or %) _____. Are office visit exams subject to deductible? Y or N

10. My co-pay for x-rays is ($ or %) _____ Are x-rays subject to deductible? Y or N

11. My co-pay amount for prescription orthotics usually referenced by "**durable medical device**" is ($ or %) _____ Are durable medical devices subject to the deductible? Y or N

12. Does my plan require pre-authorization for Chiropractic and/or Massage? Y or N
Thru which company? _____

Name _____ Signature _____ Date_____
Staff Initials

CHIROPRACTIC
NORTHWEST & Massage
www.chiropracticnw.com

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PATIENT CONSENT TO X-RAY

I authorize the performance of diagnostic x-ray examination of myself which Chiropractic Northwest may consider necessary or advisable in the course of my examination and treatment.

Signed _____ Date _____

CONSENT TO X-RAY A MINOR

I am the parent or legal representative of _____, who is a minor, _____ years of age. I authorize the performance of diagnostic x-ray examination of this child or ward which Chiropractic Northwest may consider necessary or advisable in the course of examination or treatment.

Signed _____ Date _____

FEMALES: REGARDING POSSIBILITY OF PREGNANCY

This is to certify that, to the best of my knowledge, I am not pregnant, and Chiropractic Northwest has my permission to perform diagnostic x-ray examination. I have been advised that certain x-ray examination, particularly those involving the pelvis, can be hazardous to an unborn child.

Signed _____ Date _____

FEMALES: CONSENT TO X-RAY DURING PREGNANCY

This is to certify that I am or may be pregnant and that Chiropractic Northwest has my permission to perform diagnostic x-ray examination involving my cervical spine (neck) or extremities (arms or legs), on the condition that lead shielding be utilized over the trunk of my body. I have been advised that certain x-ray examinations, particularly those involving the pelvis, can be hazardous to an unborn child.

Signed _____ Date _____

CHIROPRACTIC
NORTHWEST & Massage

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Massage Therapy Appointment Policy

Thank you for scheduling your therapeutic massage appointment in our office. Massage therapy plays a vital role in your long-term health and vitality. You are a valued patient and it is very important to us that you receive the best care while you are here!

In order for us to best help you, our patient, we need you to help us by:

- Arriving on time for YOUR appointments.
- Giving 24 hours notice to re-schedule or cancel YOUR appointment. (This allows the one hour massage reservation to be re-filled for a patient that needs it)
- Writing down YOUR appointment date & time and NOT relying strictly on text reminders. (Text reminders are not 100% reliable as they are an automated service)

If you are not able to give the 24 hour notice for cancelling or re-scheduling your appointment that you scheduled, we will charge you, not your insurance company, the $20 fee to assist in covering the loss for the reserved, one hour appointment time. No exceptions.

Thank you for your cooperation and we look forward to assisting you with your healthcare needs.

I have read and understand the above listed policy and know that it is MY responsibility to arrive on time to my appointments and to call 24 hours prior to cancelling or re-scheduling my appointments or I will be charged a $20 fee.

_____
Patient's Full Name

_____ _____
Patient to Sign Today's Date

PLEASE DO NOT SIGN THIS FORM UNTIL AFTER YOUR TREATMENT PLAN HAS BEEN REVIEWED WITH YOU BY YOUR DOCTOR

Please answer the following questions to help us determine possible risk factors:

QUESTION	YES	DOCTOR'S COMMENTS
GENERAL		
Have you ever had an adverse (i.e. bad) reaction to or following chiropractic care?	☐	
BONE WEAKNESS		
Have you been diagnosed with osteoporosis?	☐	
Do you take corticosteroids (e.g. prednisone)?	☐	
Have you been diagnosed with a compression fracture(s) of the spine?	☐	
Have you ever been diagnosed with cancer?	☐	
Do you have any metal implants?	☐	
VASCULAR WEAKNESS		
Do you take aspirin or other pain medication on a regular basis?	☐	
If yes, about how much do you take daily? _____		
Do you take warfarin (coumadin), heparin, or other similar "blood thinners"?	☐	
Have you ever been diagnosed with any of the following disorders/diseases?		
• Rheumatoid arthritis	☐	
• Reiter's syndrome, ankylosing spondylitis, or psoriatic arthritis	☐	
• Giant cell arteritis (temporal arteritis)	☐	
• Osteogenesis imperfecta	☐	
• Ligamentous hypermobility such as with Marfan's disease, Ehlers-Danlos syndrome	☐	
• Medial cystic necrosis (cystic mucoid degeneration)	☐	
• Bechet's disease	☐	
• Fibromuscular dysplasia	☐	
Have you ever become dizzy or lost consciousness when turning your head?	☐	
SPINAL COMPROMISE OR INSTABILITY		
Have you had spinal surgery?	☐	
If yes, when? _____		
Have you been diagnosed with spinal stenosis?	☐	
Have you been diagnosed with spondyliolithesis?	☐	
Have you had any of the following problems?		
• Sudden weakness in the arms or legs?	☐	
• Numbness in the genital area?	☐	
• Recent inability to urinate or lack of control when urinating?	☐	

I have read the previous information regarding risks of chiropractic care and my doctor has verbally explained my risks (if any) to me and suggested alternatives when those risks exist. I understand the purpose of my care and have been given an explanation of the treatment, the frequency of care, and alternatives to this care. All of my questions have been answered to my satisfaction. I agree to this plan of care understanding any perceived risk(s) and alternatives to this care.

PATIENT [or PARENT/GUARDIAN] SIGNATURE _____ DATE _____

INTERN SIGNATURE _____ DATE _____

DOCTOR'S SIGNATURE _____ DATE _____

Informed Consent Form Chiropractic

The doctor of chiropractic evaluates the patient using standard examination and testing procedures. A chiropractic adjustment involves the application of a quick, precise force directed over a very short distance to a specific vertebra or bone. There are a number of different techniques that may be used to deliver the adjustment, some of which utilize specially designed equipment. Adjustments are usually performed by hand but may also be performed by hand-guided instruments. In addition to adjustments, other treatments used by chiropractors include physical therapy modalities (heat, ice, ultrasound, soft-tissue manipulation), nutritional recommendations and rehabilitative procedures.

Chiropractic treatments are one of the safest interventions available to the public demonstrated through various clinical trials and indirectly reflected by the low malpractice insurance paid by chiropractors. While there are risks involved with treatment, these are seldom great enough to contraindicate care. Referral for further diagnosis or management to a medical physician or other health care provider will be suggested based on history and examination findings.

Listed below are summaries of both common and rare side-effects/complications associated with chiropractic care:

Common [1, 2]

- Reactions most commonly reported are local soreness/discomfort (53%), headaches (12%), tiredness (11%), radiating discomfort (10%), dizziness, the vast majority of which resolve within 48 hours

Rare [3, 4]

- Fractures or joint injuries in isolated cases with underlying physical defects, deformities or pathologies
- Physiotherapy burns due to some therapies
- Disc herniations
- Cauda Equina Syndrome [(2)] (1 case per 100 million adjustments)
- Compromise of the vertebrobasilar artery (i.e. stroke) (range: 1 case per 400,000 to 1 million cervical spine adjustments [manipulations]). This associated risk is also found with consulting a medical doctor for patients under the age of 45 and is higher for those older than 45 when seeing a medical doctor.

Please indicate to your doctor if you have headache or neck pain that is the worst you have every felt[(3)]

I understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. I also understand that my condition may worsen and referral may be necessary if a course of chiropractic care does not help or improve my condition.

Reasonable alternatives to these procedures have been explained to me including prescription medications, over-the-counter medications, possible surgery, and non-treatment. Listed below are summaries of concern with the associated alternative procedures.

- Long-term use or overuse of medication carries some risk of dependency with the use of pain medication the risk of gastrointestinal bleeding among other risks
- Surgical risks may include unsuccessful outcome, complications such as infection, pain, reactions to anesthesia, and prolonged recovery[5].
- Potential risks of refusing or neglecting care may result in increased pain, restricted motion, increased inflammation, and worsening of my condition[6]

Neck and back pain generally improve in time, however, recurrence is common. Remaining active and positive improve your chances of recovery.

1. Thiel HW, Bolton JE, Docherty S, Portlock JC. Safety of chiropractic manipulation of the cervical spine: a prospective national survey. *Spine*. Oct 1 2007;32(21):2375-2378; discussion 2379.
2. Rubinstein SM, Leboeuf-Yde C, Knol DL, de Koekkoek TE, Pfeifle CE, van Tulder MW. The benefits outweigh the risks for patients undergoing chiropractic care for neck pain: a prospective, multicenter, cohort study. *J Manipulative Physiol Ther*. Jul-Aug 2007;30(6):408-418.
3. Cassidy JD, Boyle E, Cote P, et al. Risk of vertebrobasilar stroke and chiropractic care: results of a population-based case-control and case-crossover study. *Spine*. Feb 15 2008;33(4 Suppl):S176-183.
4. Boyle E, Cote P, Grier AR, Cassidy JD. Examining vertebrobasilar artery stroke in two Canadian provinces. *Spine*. Feb 15 2008;33(4 Suppl):S170-175.
5. Carragee EJ, Hurwitz EL, Cheng I, et al. Treatment of neck pain: injections and surgical interventions: results of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders. *Spine*. Feb 15 2008;33(4 Suppl):S153-169.
6. Carroll LJ, Hogg-Johnson S, van der Velde G, et al. Course and prognostic factors for neck pain in the general population: results of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders. *Spine*. Feb 15 2008;33(4 Suppl):S75-82.

(over)