CHIROPRACTIC WELLNESS CENTER

618 N. Sullivan Rd Ste #21
Spokane Valley, WA 99037

NOTICE OF PRIVACY PRACTICES/CONSENTS AND AGREEMENTS

AUTHORIZATION TO RELEASE INFORMATION:

I, the undersigned, hereby authorize Provider and staff to release any information concerning my health acquired in the course of history, consultation, examination, and treatment by the Provider to my insurance company which may be necessary to help process my insurance claims. Occasionally it is necessary to communicate with other medical providers, employees of Chiropractic Wellness Center, or other referring health care professionals in the best interest of the patient. I authorize release of records to any other physician who is, was, or may be one of my treating physicians. In addition, I authorize release of information from previous physicians to Provider. This includes lab reports, test results and reports, x-rays, MRI's, etc. These authorizations include phone discussions between Provider and said physician. I release Provider of any liability resulting from such information transference.

____ ______________

Signature of patient or parent/guardian of patient **Date**

AUTHORIZATION TO RECEIVE COMMUNICATION:

I, the undersigned, hereby authorize Provider and staff to communicate with me via internet, mail, telephone, or text pertaining to upcoming events, promotions, updates, newsletters, and health status checkups. As a courtesy to our patients, we may call, text, or email prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we may leave a message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this message other than the date and time of your scheduled appointment.

____ ________________

Signature of patient or parent/guardian of patient **Date**

NOTICE OF PRIVACY PRACTICES:

You have the right to request restrictions on certain uses and disclosures of your health information.
You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method or communication or delivery upon your request.
You have the right to inspect and copy your health information.
You have the right to receive an accounting of disclosures of your protected health information.
You have the right to a paper copy of this Notice of Privacy Practices at any time upon request.

I provide Chiropractic Wellness Center with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment, and health care operations as described above.

____ ________________

Signature of patient or parent/guardian of patient **Date**

CONSENT TO TREAT A MINOR:

I hereby authorize the doctor to render chiropractic care as deemed necessary to:
Child's Name ____Date_______________________
Guardian's Name (please print) ________________________________Relationship to Child__________________
Guardian's Signature____

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New Patient Payment Plan

Please choose ONE option & initial next your method of payment for services rendered.

_____ **Cash:** Payment is expected at the time services are rendered.
We accept **Cash, Check, MasterCard, and Visa.**

_____ **Insurance:** You need to provide our office with a **copy of your insurance card**. Our office will bill your insurance company as a courtesy to you with the understanding that **you are ultimately responsible for your account in our office**. In the event that your insurance company denies payment of services rendered, **you are responsible for any unpaid balances**. If you have co-insurance, where you would pay a percentage of your bill, the amount owed will be estimated and billed to you as services are rendered. Should any credit be incurred, that amount will be returned to you upon completion of care. **You are responsible for your annual deductible**.

Let us know if you have not met your deductible prior to care.

_____ **Medicare: You are responsible for services rendered that are not covered by Medicare**. Medicare does not pay for exams, x-rays, and other supplies. You will need to pay for x-rays and examinations at the time the services are rendered**.**

You are also responsible for your yearly deductible.

_____ **Personal Injury: It is your responsibility to provide our office with any and all pertinent insurance information** (I.E. PIP, third party, or health insurance.) We need all insured persons names, addresses, and phone numbers. We also need all claim numbers, claim adjuster's names, addresses, and phone numbers. If you are being represented by an attorney we will gladly work with him/her. We accept third party liens for those without PIP coverage. However, we require a $75.00 non-refundable fee to administer the lien. Any accounts over 60 days will accrue interest at a rate of 1% per month (12% per year).

You are responsible for all services rendered by our office, regardless of settlement outcome. Our fees are consistent with industry standards and are usual and customary. If you decide to stop care or transfer to another doctor before you have completed your treatment schedule *payment becomes due immediately*.

_____ **Work Related Injury:** You are responsible for filling out the self-insured Labor and Industries long form or the self-insured L & I form. You also need to file an accident report with your employer prior to your appointment with our office. If you are transferring care from another physician, we have transfer cards available. **If your claim is not accepted for any reason, you will be responsible for your account balance.**

___________________________________ ________________________
Signature Today's Date

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CONFIDENTIAL PATIENT HEALTH RECORD

First Name ______________________________
Middle Initial _________
Last Name ______________________________
Nick Name _____________________
Street Address ___________________________
City _____________________________________
State ________ Zip ___________
Home Phone ( ) ______-___________
Work Phone ( ) ______-___________
Cell Phone ( ) ______-___________
Would you like text reminders? Y____ N____
Cell phone carrier___________________
Email _____________________________

Birth Date _____/_____/_____
Age _______
Gender M____ F____
SSN _______-____-__________
Occupation ___________________________
Employer _____________________________
Marital Status S M W D
Spouse Name __________________________
Spouse Employer _______________________
Spouse Phone ( ) _____-_________
Emergency Contact Name _______________
Emergency Contact ( ) ______-_________
Physician Name ________________________
Physician Phone ( ) ______-_________

Referred By _______________________________
May we thank them for your referral? Y____ N____

CURRENT HEALTH CONCERNS

What is your main complaint? ____
When did you first notice symptoms? ____
Is the complaint related to past injuries/accidents? NO _______ YES _______
If yes, please explain: ____
On a 1-10 scale (0 = no pain), rate your pain **currently** ________ At its **worst** __________
How often are you bothered by pain? ____
Are there regular activities you **cannot** do because of pain? __________________________
Check any that apply:
Pain travels _____ Worse in evening _____ Worse in morning _____ Limits movement _____
Are you on medications? No _____ YES _____
If yes, please specify all: ____
Would you classify your condition as: **Minor** ____ **Moderate**____ **Serious** _____ **Severe** _____

I declare that these statements are true to the best of my knowledge.

Signature _______________________________ **Date ______/______/______**

Please check/circle all that apply

Structure

Headaches (circle all that apply)

- ___ Stress   Migraine
- ___ Jaw pain/Clicking/Popping
- ___ Neck Pain
- ___ Mid-back pain
- ___ Pain between shoulder blades
- ___ Chest pain
- ___ Lower back pain/sciatica
- ___ Hip/Groin pain

Are you experiencing any pain in these areas? (circle all that apply)

L	R	Shoulder	L	R	Upper arm
L	R	Elbow	L	R	Forearm
L	R	Wrist	L	R	Knee
L	R	Ankle	L	R	Foot

- ___ Numbness/Tingling
- ___ Location: ____________
- ___ Stiff or Swollen joints
- ___ Muscle weakness
- ___ Muscle soreness
- ___ Muscle Cramps/Spasms
- ___ Muscle Tension/Tightness
- ___ Dizziness
- ___ Seizures
- ___ Confusion
- ___ Convulsions
- ___ Problems Walking
- ___ Limited/Painful movement
- ___ Pain limits doing what you like

Family Health History

- ___ Diabetes
- ___ High Blood Pressure
- ___ High Cholesterol
- ___ Heart Disease
- ___ Anemia
- ___ Stroke
- ___ Thyroid Disease
- ___ Arthritis
- ___ Osteoporosis
- ___ Alzheimer's
- ___ Cancers ____________

____

Other ____________

____

Exercise

Type of exercise you do…

- ___ Aerobic/Cardio
- ___ Endurance
- ___ Toning
- ___ Strength

Other ____________

How often? ____________

Level of Intensity ____________

Is there any type of exercise you would like to participate in, but currently can't? ____________

____

Stress

- ___ Depression
- ___ Nervous/Anxious
- ___ Stressed
- ___ Fatigue
- ___ Irritability
- ___ Forgetfulness
- ___ Sick often
- ___ Allergies/Hay Fever
- ___ Sinus Infections
- ___ Asthma/Bronchitis

Nutrition

- ___ Weight Gain/Loss
- ___ Appetite Change
- ___ Always Thirsty
- ___ Eczema/Psoriasis
- ___ Itchy Skin
- ___ Vision Changes
- ___ Eyes bothered by light
- ___ Ringing in ears
- ___ Loss of hearing
- ___ Earaches
- ___ Increase/decrease in urination
- ___ Eating Disorders
- ___ High Cholesterol
- ___ High LDL/Low LDL
- ___ Indigestion/Heart Burn
- ___ Acid reflux/Stomach ulcer
- ___ Diverticulitis/Colitis
- ___ Irritable Bowel
- ___ Crohn's Disease
- ___ Mood swing changes

Posture

Have you been told or have you noticed any of the following?

- ___ Reversed Cervical curve
- ___ Forward Neck
- ___ Hunched Back
- ___ Rounded Shoulders
- ___ Swayback
- ___ Scoliosis/Kyphosis
- ___ Foot flare   Right   Left
- ___ Low/High Hip

Low/High Shoulder

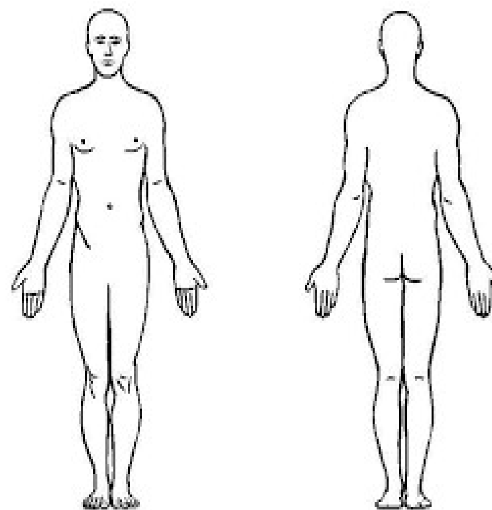
Sleep

Sleeping position(circle one)

- ___ Side   Back   Stomach
- ___ Sleep Disturbance
- ___ Number of hours per night
- ___ Difficulty falling asleep
- ___ Wake up and can't go back to sleep
- ___ Restless Leg Syndrome

Snoring/Sleep Apnea

Insomnia



PAIN DIAGRAM

Please mark your areas of pain on these figures, indicating which type of pain you are experiencing.

B = Burning   D = Dull

S = Sharp   T = Tingling

N = Numbness

next to the letter by using the following scale:

0 = No Pain

8 = Brings tears to your eyes

10 = Severe medical emergency

I declare these statements are true to the best of my knowledge.

____________________ *Signature*   ____________ *Date*

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Massage Therapy Notice of Cancellation Policy

Because we pay our massage therapists for their time to be here for your scheduled appointment, we have a Notice of Cancellation Policy for missed appointments. The policy is as follows:

Our office requires **24-hour notice** for a massage therapy cancellation.

If we fail to receive notice of cancellation 24 hours prior to the scheduled appointment time, ***a Missed Appointment Fee of $40.00 will be billed to you personally.***

The missed appointment fee cannot be billed to or paid by your insurance company.

We will make every effort to give you a reminder text or call, but ultimately you are responsible for your scheduled appointment. Please provide your preferred contact information for a reminder text or call.

Thank you for your understanding and consideration.
We look forward to serving you!

I have read and agree to the *Notice of Cancellation Policy*.

Date : _________

Patient Signature : ______________________________

Print name: ___________________________________

Cell Phone Number: ____________________________