

Spinal & Sports Care Clinic, PS
12905 E Sprague Ave., Spokane Valley, WA 99216

First Name (Legal): _____ (MI): _____ Last Name: _____

Social Security Number: ___/___/___ Birth Date: ___/___/___ Married Single Other

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Number: _____ Cell Number: _____ Work Number: _____

May we leave a message if we need to? Yes No E-mail address: _____

Occupation: _____ Patient Employer/School: _____

Military: Active Veteran N/A Who may we thank for referring you? _____

In Case of Emergency Contact

Name: _____ Relationship to patient: _____

Phone Number: _____ Work Number: _____

Insurance Information

Who is responsible for this account?: _____ Relationship to patient: _____

Primary Insurance Company: _____ Phone Number: _____

Subscriber Name: _____ Subscriber Date of Birth: ___/___/___

Insurance ID: _____ Group Number: _____

Employer: _____ Work Number: _____

Secondary Insurance Company: _____ Phone Number: _____

Subscriber Name: _____ Subscriber Date of Birth: ___/___/___

Insurance ID: _____ Group Number: _____

Employer: _____ Work Number: _____

I understand it is my responsibility to provide Spinal & Sports Care Clinic with accurate information concerning my insurance coverage and personal information. I understand that all quotes are an estimate and all balances are subject to the information Spinal and Sports Care Clinic received from my insurance carrier. I understand there are no guarantees of benefits and I am financially responsible for all charges rendered whether or not paid by my insurance. I authorize Spinal & Sports Care Clinic the use of my signature on all insurance submissions. I also authorize Spinal & Sports Care Clinic to provide information to my insurance carrier(s) and their agents for the purpose of obtaining payment for services rendered and assign directly to Spinal & Sports Care Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand Spinal & Sports Care Clinic will not become involved in any dispute between me and my insurance company. It will be my responsibility to settle any such dispute.

Print Patient Name

Date

Signature of patient/parent/guardian/personal representative

Relationship to Patient

NAME _____

DATE ____/____/____

Are you here because of an **AUTO ACCIDENT?** Y / N **WORK INJURY?** Y / N

Current Complaint

What is your problem(s)? _____

When did it begin? _____

The onset was () Sudden () Gradual

Has this occurred before? () Yes () No If so, when? _____

Have you tried any other treatments for this condition? () Yes () No Physical Therapy () Y () N
Results? _____

Have you previously been under chiropractic care () Yes () No
If yes, with whom? _____ Date of last visit? _____

Is your problem () Getting worse () Getting Better () Staying the same

Does anything help decrease your symptoms? _____

Check any of these activities that increase your pain:

- () Bending () Standing () Sitting () Lying down
() Lifting () Walking () Coughing () Straining with bowel
() Driving in car () Standing up from a chair movement

Lifestyle Restrictions

Are you more irritable due to this condition? () Yes () No

Have you missed any work due to this condition? () Yes () No How long? _____

Does the pain interfere with your sleep? () Yes () No

Are you unable to perform any of these activities:

- () Sports () Recreation () Hobbies
() Cleaning the House () Yardwork

Past Health History

Major surgeries () Yes () No Describe: _____

Previous auto accidents or injuries () Yes () No Describe: _____

Have you ever been hospitalized? If So, Describe: _____

Have you been diagnosed as having any of these health problems:

- () Yes () No High Blood Pressure? () Yes () No Diabetes?
() Yes () No Stroke, TIA, or Heart Disease? () Yes () No Cancer?

Are you a smoker? () Yes () No () Former smoker

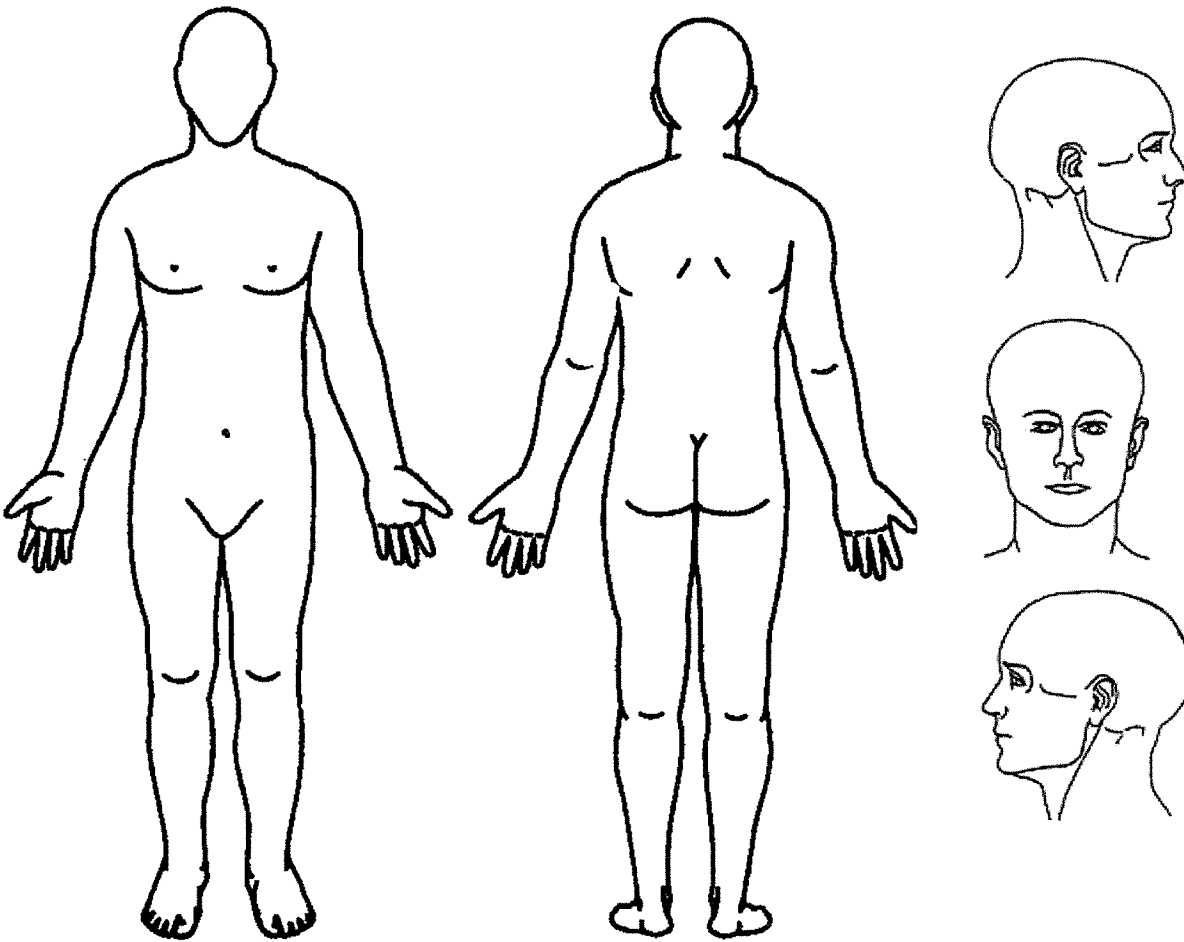
Any other serious health problems not listed? _____

Are you currently taking any medications? Describe _____

- () Pain killers () Muscle relaxants () Steroids
() Blood Pressure Medicine () Blood thinners

Please complete this drawing carefully. Mark on the drawing the areas where you feel the described sensation. Use the appropriate symbols and include all involved areas of your body.

NUMBNESS === PINS & NEEDLES OOO ACHING PAIN !!!
 BURNING PAIN xxx STABBING PAIN III



Main Complaint is: _____

| | | | | | | | | | | |
|----------------|---|------------|---|---|-----------------|---|---|----------------|---|------------------|
| | | | | | | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| <u>NO PAIN</u> | | <u>LOW</u> | | | <u>MODERATE</u> | | | <u>INTENSE</u> | | <u>EMERGENCY</u> |

Secondary Complaint is: _____

| | | | | | | | | | | |
|----------------|---|------------|---|---|-----------------|---|---|----------------|---|------------------|
| | | | | | | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| <u>NO PAIN</u> | | <u>LOW</u> | | | <u>MODERATE</u> | | | <u>INTENSE</u> | | <u>EMERGENCY</u> |

Informed Consent

Before beginning treatment, it is our office policy to inform you of what to expect, possible complications of chiropractic, as well as complications of other forms of treatment. Remember that all forms of treatment (including non-treatment!) have associated risks. **If you have any questions, please be sure to ask the doctor.**

What to expect

The treatment at our office will consist of manipulation of the joints and soft tissues, using the hands and/or a mechanical instrument. You may feel movement, and you may hear joint clicks or other noises. Physical therapy methods, including therapeutic exercise, massage and heat or ice may also be used.

Chiropractic risks

Chiropractic treatment is one of the safest methods of treating spinal problems. Still, unexpected problems can occur. Minor, temporary problems, such as soreness and stiffness can occur, especially in the beginning of a treatment plan. More significant problems, such as fracture of a weakened bone or sprain/disc injuries are rare. A stroke following neck manipulation is an extremely rare complication, occurring less than 1 per million treatments. Stroke has also been the result of ordinary activities, such as head turning or stargazing.

Other treatments and risks

There are other treatments used by medical doctors. Their risks include:

Medications: Many commonly used medications, such as NSAIDs (e.g., Advil, Aleve or Tylenol), carry risks of tissue damage, including stomach ulcers or kidney damage. This damage can occur quickly, and may be irreversible. There is a significantly higher risk of developing a serious complication with NSAIDs as opposed to chiropractic. Other medications are habit forming, and may mask pain to allow further tissue damage.

Surgery: Surgery is the treatment of choice in less than 1% of back pain patients. Your doctor has screened for surgical "red flags", and will refer you for a surgical opinion if indicated. Clinical results of surgery for mechanical back pain have been disappointing, and exposes you to unnecessary hospital and medication risk.

Rest/non-treatment: Bedrest has been shown to increase the likelihood of re-occurrence of back episodes, and make chronic pain more likely. Likewise, non-treatment may cause a permanent mechanical problem to develop, causing future back problems.

I have read the above, and give my consent to begin chiropractic treatment.

Printed Name: _____

Date: _____

Signature: _____

Financial Policy

Payment Methods

We accept cash, checks, Visa, Master Card, American Express, Discover and debit cards.

Self Pay

If you have no insurance or insurance that has no chiropractic benefits, payment at the time of service will be expected, unless prior arrangements have been made. We offer at time of service discount for payment in full on the day of service.

Insurance

We are contracted with most insurance companies. However, some insurance companies arbitrarily select certain services that they will not cover and/or must be medically necessary. It is your responsibility to understand the scope and limitations of your insurance policy and you are financially responsible for all charges rendered whether or not paid by your insurance. *At the time of service you are responsible for all co-pays, deductibles and any estimated fees for services not covered by your insurance plan.* As a courtesy we will bill your insurance company; however it is your responsibility to provide us with accurate information.

Examination & Re-examination

Should I have a new complaint or if it has been over 1 year since my last visit a new examination will be completed. If my insurance does not pay for this service it is my responsibility to pay in full at time of service unless prior arrangements have been made.

Motor Vehicle Accident

You will not be responsible for paying at time of service if you have a personal injury protection coverage plan we can bill for your care. If you've exhausted your personal injury protection coverage you will be financially responsible for all charges rendered whether or not paid by the insurance carrier.

Workman's Compensation/Self Insured/Federal

You will not be responsible for paying at time of service if you have an open L&I claim or filing for L&I. If your L&I claim has been denied or closed within the course of treatment you are financially responsible for all charges rendered whether or not paid by L&I.

NO Show Policy

You will be considered a no show if you miss an appointment and do not notify us at least four hours in advance. A \$25.00 charge will be applied to your account and must be paid prior to being seen by the provider at your next visit. If you miss two appointments in a row, any remaining appointments will be cancelled and you will not be able to schedule with the provider until all fees are paid. If you miss three appointments without canceling you may be discharged from care.

I have read and understand the above terms and I accept full responsibility for the services incurred with Spinal and Sports Care Clinic.

Print Name

Signature

Date

PATIENT AUTHORIZATION FOR RELEASE OF PHI

Patient Name _____ Date of Birth: _____

Address _____

Phone Number _____ Chart Number _____

By signing this form, I authorize Spinal and Sports Care Clinic PS to use and/or disclose my:

- **Protected Health Information (PHI):** PHI means information about a patient, including demographic information that may identify a patient, that relates to the patient's past, present or future physical or mental health or condition, related health care services or payment for health care services
- **Sensitive Protected Health Information (SPHI):** SPHI means Protected Health Information that pertains to particularly sensitive information, as defined by state law, such as (i) an individual's HIV status or treatment of an individual for an HIV-related illness or AIDS, or (ii) an individual's substance abuse condition or treatment of an individual for mental illness.

I authorize disclosure of the following information from my medical record:

Note: Include a detailed description of information to be released including dates.

Release medical records to my medical provider or attorney listed below:

Name: _____ Telephone: _____

Address _____

I authorize Spinal & Sports Care Clinic to provide information regarding my personal information such as appointments, bills, or general account information to: (spouse, partner, parent, etc.)

Name: _____ Telephone: _____

Address _____

(Spinal & Sports Care Clinic, by law, cannot speak to anyone regarding personal information unless we are authorized by you to do so!)

I Understand that:

- Treatment will not be conditional on whether I sign this Authorization.
- This Authorization is voluntary and that I have the right to refuse to sign it.
- If I sign this authorization, I may revoke it later by sending a written notice of revocation to the privacy office at the practice.

Note: The only exception to your right to revoke is if the practice has already acted in reliance upon the authorization.

- Once signed, the Practice will provide me with a copy of this Authorization.
By signing this form below, I acknowledge that I have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:
- Conduct, plan and direct my treatment and follow-up among the health care providers who may be

directly and indirectly involved in providing my treatment.

- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and accreditation.

By signing this form below, I acknowledge that I have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and accreditation.

Signature(s)

Patient signature _____ Date _____

Sign below if you are a personal representative of the patient.

Representative signature _____ Date _____

Print Name _____

Relationship to Patient _____

For Office Use Only

Verification Method: _____

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the Acknowledgment
- An emergency situation prevented us from obtaining Acknowledgment
- Other (Please Specify) _____

Staff signature

Date

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name: _____ Last Name: _____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ Gender (Circle one): Male / Female Preferred Language: _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

| Medication Name | Dosage and Frequency (i.e. 5mg once a day, etc.) |
|-----------------|--|
| | |
| | |
| | |

Do you have any medication allergies?

| Medication Name | Reaction | Onset Date | Additional Comments |
|-----------------|----------|------------|---------------------|
| | | | |
| | | | |
| | | | |

I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight: _____ Blood Pressure: _____ / _____