wholehealthshoreline.com
chiropractic

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CHIROPRACTIC INTAKE FORM

First name: Last name: Birthdate:

Please refer to me by: Gender: □ Male □ Female □ Other:

Address: Suite/Apt:

City: State: Zip:

Home Phone: Cell Phone: Work Phone:

E-mail: Ok to send e-mails? Y / N

Marital Status: □ Single □ Married □ Divorced □ Widowed

Emergency Contact Name: Phone Number:

Relationship:

Employment Status : □ Employed □ Unemployed □ FT/PT Student □ Other:

Employer: Occupation:

Employer Address:

PRIMARY INSURANCE

Insurance Company Name: Are you the primary subsriber? Y / N

Policy/ID # Group#

Name of Subscriber: Subscriber Date of Birth:

Relationship to the Subscriber: Subscriber's Employer:

SECONDARY INSURANCE

Insurance Company Name: Are you the primary subsriber? Y / N

Policy/ID # Group#

Name of Subscriber: Subscriber Date of Birth:

Relationship to the Subscriber: Subscriber's Employer:

REASON FOR YOUR VISIT

How did you hear about us?

Have you ever been treated by a chiropractor before? Y / N

If so, please explain:

The reason for this visit is a result of: Work Auto Chronic Acute Injury

When did this condition begin? Is it getting worse? Y / N

Please describe your condition:

Have you been treated by a Medical Physician for this condition? Y / N

If so, where?

HEALTH HISTORY

Are you taking any of the following medications?

☐ Nerve pills ☐ Pain killers (including aspirin) ☐ Muscle relaxers ☐ Stimulants

☐ Tranquilizers ☐ Birth control ☐ Blood thinners ☐ Insulin

☐ Other prescribed medications: ____

Have you ever had any of the following diseases or medical conditions?

Y / N	Heart attack / Stroke	Y / N	Heart Surgery / Pacemaker
Y / N	Congenital Heart Defect	Y / N	Mitral Valve Prolapse
Y / N	HIV+ / AIDS	Y / N	Shingles
Y / N	Frequent Neck Pain	Y / N	Emphysema / Glaucoma
Y / N	High / Low Blood Pressure	Y / N	Psychiatric Problems
Y / N	Severe / Frequent Headaches	Y / N	Kidney Problems
Y / N	Fainting / Seizures / Epilepsy	Y / N	Sinus Problems
Y / N	Diabetes / Tuberculosis	Y / N	Difficulty Breathing
Y / N	Lower Back Problems	Y / N	Artificial Bones / Joints
Y / N	Heart Murmur	Y / N	Artificial Valves
Y / N	Hepatitis	Y / N	Cancer
Y / N	Anemia	Y / N	Rheumatic Fever
Y / N	Ulcers / Colitis	Y / N	Asthma
Y / N	Chemotherapy	Y / N	Arthritis

Please list any other serious medical condition(s) you have or have had:

List previous surgeries / treatments with dates:

List any past serious accidents with dates:

Family health history:

Are you currently pregnant?	Y / N	How many weeks?		Nursing?	Y / N
Do you smoke?	Y / N	How much?		For how long?	
Are you wearing:	☐ Heel lifts	☐ Sole lifts	☐ Inner soles	☐ Arch supports	
What is the age of your mattress?			Is it comfortable?		

PAIN DIAGRAM

Please indicate where you are experiencing pain.

Key:

A- Ache B- Burning P- Pins & Needles

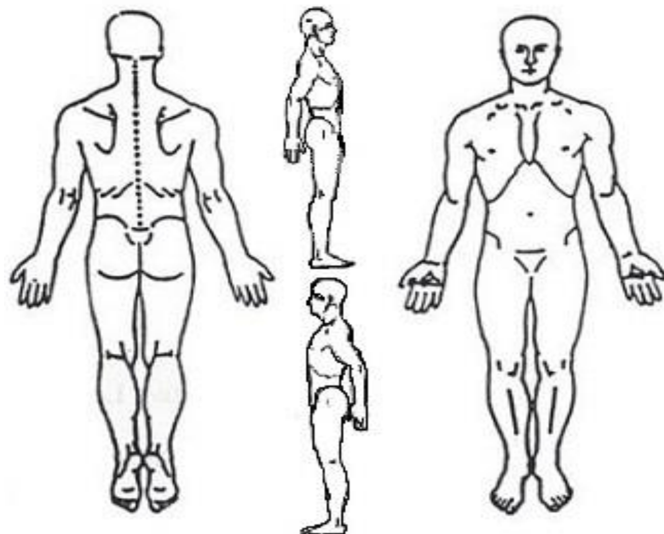
S- Stabbing N- Numbness O- Other

* Circle any area not represented by a symbol

Pain Level: (*None*) 0 1 2 3 4 5 6 7 8 9 10 (*Worst*)

Height: ______ft ______in

Weight: __________ lbs



SIGNATURE: **DATE:**

Terms of Acceptance

When a patient seeks Chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will use to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our Chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being—not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I, ___________________________________ have read and fully understand the above statements.
(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

____

(Signature) *(Date)*

FINANCIAL POLICY

The following is an explanation of our clinic policies. We believe that a clear definition will allow us to both concentrate on the most important issue: regaining and maintaining your health. We will be happy to answer any questions you may have regarding our policies.

CANCELLATION POLICY

Our clinic requires 24-hour notice for cancelling or rescheduling appointments. Missed appointments or failure to give proper notice will result in a **$50 fee**. The purpose of this fee is to encourage our patients to take their appointments as seriously as we do. Cancellations of convenience or last-minute schedule conflicts will be your responsibility. There are few exceptions to this policy which include: acute health problems, personal/family crises, and hospitalization. We remain available to discuss this policy in general, or by individual circumstances.

PATIENT PAYMENT POLICY

Payment (including copays, coinsurance and deductibles) is expected at the time of service unless prior arrangements have been made. In the event where you do not have insurance coverage, we will honor the time-of-service rate appropriate to the service you receive. We are here to serve everyone in the community, which means making sure that money is never a barrier to good healthcare.

OUR POLICY ON HEALTH INSURANCE

We will be happy to file your primary insurance claim for you and do everything we can to ensure you receive proper reimbursement. However, we cannot take responsibility for what your insurance will or will not cover. The insurance company makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, you are responsible for initiating the process within the required time frame. Failure to obtain the referral and/or preauthorization may result in denial of payment from your insurance company.

STATEMENTS

If you have a balance on your account, we will send you a statement. Statements are sent out after the summation of credits and adjustments have been applied. To avoid interest rates from incurring, please make payments within 28 days from the posted date. A re-billing fee of $5 may be imposed on each account that is over thirty (30) days past due.

OUR POLICY ON PAST DUE ACCOUNTS

If your account becomes past due, we will take necessary steps to collect the debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees acquired plus all court costs.

RETURNED CHECKS

There is a fee of $45.00 for any checks returned by the banking institution.

The financial policy continues on the back side of this page →

CREDIT HISTORY

Upon signing, permission is granted to check your credit and employment history in addition to answering questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau.

TRANSFER OF RECORDS

Written consent by the account holder is required for us to send personal health information to any facility or physician's office outside of Whole Health Chiropractic. The amount of the fee is dependent on the number of pages we need to duplicate. You authorize us to include all relevant information, including payment history. If you are requesting your records to be transferred from a third party to Whole Health Chiropractic, you approve us to receive all relevant information along with payment history.

WAIVER OF CONFIDENTIALITY

You understand if your account is submitted to an attorney, collection agency, court litigation, or credit reporting agency, it may become a matter of public record.

WORKER'S COMPENSATION

If you are being treated as part of your work-related injury and do not have a claim open, we will initiate the claim process with Washington State's Department of Labor and Industries on your behalf. If your claim is denied, you will be responsible for payment in full.

PERSONAL INJURY

If you are being treated as part of a personal injury lawsuit or claim, we will require verification from your attorney or insurance company prior to your visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be negotiated.

DIVORCE

In case of a divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After the divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

EFFECTIVE DATE

Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full effect.

I have read Whole Health Chiropractic's Financial Policy and agree to honor them:

Patient Name:____

Responsible Party Name (if not the patient): ____

Signature: ____________________________________Date: _________________

Consent for Release of Information
Responsibility for Payment
HIPAA Privacy Notice Acknowledgment

I consent to the use and disclosure by Whole Health Chiropractic & Associates ("the Office") any information, e.g. health information concerning my examinations and products, to any party and/or agent including, but not limited to my employer, health plan or plan sponsor ("Plan"), as needed for my treatment, the payment of my benefit claims, and related customer communications regarding health care services provided by the Office (e.g. mailings of exam reminder/recall cards or explanations of services/products provided by the Office.

If I desire to seek third party reimbursement for the services received, I authorize the Office to submit a benefit claim for payment to any third party as identified. I understand that I am responsible for all charges incurred, including any portion not paid by any third party.

I understand that this consent for release of information is voluntary and I may revoke my consent at any time by notifying the Office in writing, except for any disclosure already taken in reliance of my consent to release of information. I understand that I may request the Office to restrict the use and disclosure of my information; however, the Office is not required to agree to my request.

I acknowledge and agree that I have been offered a copy of the Notice of Privacy Practices for review and to keep for my records on the date identified below. I can be assured that the Office does not sell personal health information of any kind to a third party for such party's own use.

____ ________________

Signed (Patient or Legal Representative) Date

____

Legal Representative's Relationship