

# BACK & NECK CARE CHIROPRACTIC

## Confidential Patient Information

All information will be kept strictly confidential. Your responses will help determine if chiropractic, acupuncture or massage will benefit you. Unless we sincerely feel that your condition will respond satisfactorily, we will not recommend treatment.

### Patient Information

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_  
Cell (\_\_\_\_) \_\_\_\_\_  
Social Security Number \_\_\_\_\_  
Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex:  M  F  Other  Withheld  
Current Height: \_\_\_\_\_ / Weight: \_\_\_\_\_  
 Married  Single  Widowed  Separated  Divorced  
Occupation \_\_\_\_\_  
Employer \_\_\_\_\_  
Employer Address \_\_\_\_\_  
Work Phone (\_\_\_\_) \_\_\_\_\_  
Spouse's Name \_\_\_\_\_  
Spouse's Occupation \_\_\_\_\_  
Number of Children: \_\_\_\_\_  
Race: Asian/Pacific Islander, Black or African American, Caucasian, Hispanic or Latino, Native American, Withheld  
Ethnicity: Non-Hispanic, Hispanic, Withheld  
Who may we thank for referring you?  
Advertisement/ Insurance / Web / Friend or Family?  
NAME: \_\_\_\_\_

### Accident Information

Is condition due to an Accident?  Yes  No  
Date of Accident \_\_\_\_\_  
Type of Accident  Auto  Work  Home  Other \_\_\_\_\_  
To whom have you reported the Accident?  
 My Auto Insurance  Third Party's Auto Insurance  
 Employer  Worker's Comp  Other \_\_\_\_\_  
Attorney Name (if applicable) \_\_\_\_\_  
Attorney Phone number \_\_\_\_\_

Please provide your medical doctors contact information, we would like to personally report the status of your health condition to them.

Doctors name: \_\_\_\_\_ MD / DC / DO  
Clinic/Group \_\_\_\_\_  
Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

### Emergency Contact

In case of an emergency, whom may we contact?  
Name \_\_\_\_\_ Phone \_\_\_\_\_  
Relationship \_\_\_\_\_ Work Phone \_\_\_\_\_

### Email/Text Correspondence

If you would like to receive text or e-mail alerts for your upcoming appointments, please provide the following information. You may unsubscribe at any time by contacting our office.

Email Address: \_\_\_\_\_  
Cellular Provider(AT&T, Sprint, Verizon, etc): \_\_\_\_\_  
*Your security is our first priority. We have a strict do-not-sell policy that we take very seriously. No one else has access to your personal account information, subscriber details, or contact list.*

Are you Pregnant?  Yes  No  
Due Date \_\_\_\_\_  
Do you have:  
High Blood Pressure  Yes  No  
Pacemaker  Yes  No  
Cardiac or Circulatory Problems  Yes  No  
Do you bruise easily  Yes  No  
Infectious Disease  Yes  No

### Consent To Treat

I hereby authorize the doctor(s) or other providers of this clinic and whomever they may designate as their assistants to administer treatment as they so deem necessary.  
I, also authorize the release of information about my physical condition to my insurance company and/or attorney in order to process my bills for payment. I give permission to share private and medical information with my Medical Doctor as well as his/her staff. They have permission to share private and medical information with this office as it pertains to my health care. I certify that the above information is true and correct.  
I understand that I am ultimately responsible for all bills occurred. When/If Insurance benefits are quoted, it is not a guarantee of payment, claims will be reviewed at the time they are received. As a courtesy to our patients we provide complimentary insurance billing. However, we are not responsible for claim status and processing.

Signature of Patient (or Patient's Guardian):

Name: \_\_\_\_\_ Date: \_\_\_\_\_

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What Are Your Complaint(s)? \_\_\_\_\_

### Are there ASSOCIATED SYMPTOMS with Complaint(s)?

- Fatigue, Headache, Morning Stiffness,
- Numbness Radiating to Arms-Legs,
- Are there any Bowel or Bladder issues?

### What is the QUALITY OF YOUR PAIN?:

- Aching, Burning, Dull, Intermittent, Shooting, Stabbing, Throbbing, \_\_\_\_\_
- Headache is Worst Ever
- Decreasing, Improving, Worse,

### What is the SEVERITY of Your Complaint?:

- **MILD, MODERATE, SEVERE**
- What Activities does this Interfere with:  
Household Activities, Normal Lifestyle, School, Sleeping, Work, Sex, Sports, Finances, Playing with Kids, \_\_\_\_\_
- **PAIN LEVEL:** No Pain = 0- 1- 2- 3- 4- 5- 6- 7- 8- 9- 10

### What is the DURATION of Your Complaint?:

- Length of Time this Episode has been Present? \_\_\_\_\_ Days / Months / Years

### What is the TIMING of Your Complaint?: Symptom Onset was: Abrupt, Gradual,

#### Is it CONSTANT or FREQUENT?

- **Started with:** Increased Activities, Bending, Long Drive, Fall, Illness, Lifting, Moving Furniture, Vehicle Accident, Occupational Injury, Sleeping, Sports, \_\_\_\_\_
- **Injury Date** \_\_\_\_\_
- **Worse with:** Bending, Coughing, Driving, Lifting, On Feet, Physical Activity, Sitting, Standing, Walking
- **Gets Better With:** On Feet, Physical Activity, Resting, Sitting, Standing, Walking, \_\_\_\_\_

### What is the Context of your Complaint?:

- **Your Work Status:** Not improved enough to return to work, Returned to work but couldn't continue
- **Did you have an X-ray?** Was told X-ray was: Normal/Abnormal

### Are there any MODIFYING FACTORS to your Complaint?: Any Current/Previous Treatment?

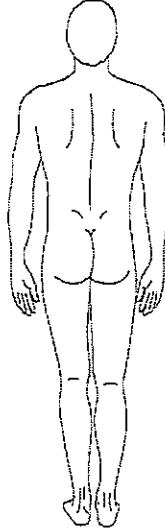
Acupuncture, Cold Pack, Chiropractic, Massage, Medical, Physical Therapy, \_\_\_\_\_

What is your **GOAL FOR TREATMENT?** i.e. Be able to do a Specific Task? Pain Free? \_\_\_\_\_

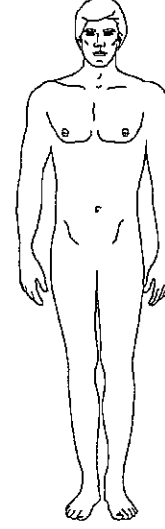
If this is a long term problem; why are you treating now? \_\_\_\_\_

**Please MARK your Areas of Pain**

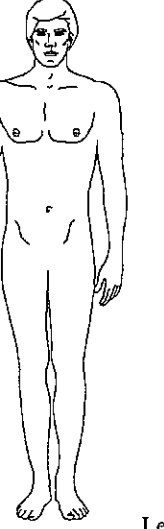
A=Aching / B=Burning / S=Stabbing / P=Pain  
N = Numbness / T = Tingling /  
W = Weakness



Left



Right



Left

## PAST HEALTH HISTORY

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

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*Please answer for any of the following conditions you Currently have or Have had.*

<u>FAMILY HEALTH HISTORY</u>	<u>Age</u>	<u>Health Issues</u>
Father		
Mother		
Sibling		
Grandparents		

**SOCIAL HISTORY (PLEASE CIRCLE ANSWERS THAT APPLY)**  
**EXERCISE:** None / Aerobic / Avoids due to Pain / Frequent / Infrequent / Limited / Occasional / Regular

**HISTORY GIVEN BY:** Care Giver / Child / Guardian / Parent / Self / Spouse / Translator

**MEDICAL CARE:** Dental Exam (date): \_\_\_\_\_ Eye Exam (date): \_\_\_\_\_ Physical (date): \_\_\_\_\_ / Never had one

**WORK ENVIRONMENT:** No problems/Stressful/Constant sitting/Constant Standing/Heavy Data Entry/Lifting

**SMOKING STATUS:** Smokes everyday/ some days/ Former Smoker/ Never a Smoker/ Unknown

**SUBSTANCE USE:** Alcohol: \_\_\_\_\_ Caffeine \_\_\_\_\_ Opiates: Codeine, Demerol, Hydrocodone, Morphine

**IMMUNIZATION / VACCINATIONS:** Influenza Date \_\_\_\_\_ Pneumonia Date \_\_\_\_\_

<b>DRUG ALLERGIES? (List)</b>			
<b>CURRENT MEDICATION NAME</b>	<b>For What Symptom?</b>	<b>How Many Times a Day?</b>	<b>Strength?</b>

**REVIEW OF SYSTEMS** PLEASE CIRCLE any items that CURRENTLY PERTAIN TO YOU:

**MUSCULOSKELETAL:** General: Numbness. -Disability: Able/Unable to work. -Kidney/UTI problems. Muscles: Ache, Atrophy, Wasting, Weakness. -Posture is Abnormal. -Skeletal System: Arthritis, Artificial Joints, Gout, Joint Pain, Osteoarthritis, Psoritaic or Rheumatoid Arthritis. -Spine Problems: Back Injury history, Back Surgery Date \_\_\_\_, Neck Injury. -Trauma or Recent Injury.

**NEUROLOGIC:** Problems with: Incontinence, Dysphasia, Hearing, Neck limitation of motion, Orofacial paresthesia, Smell, Speech Swallowing Taste, Visual. Dizziness, Headaches, Trauma to head, Vertigo.

**INTEGUMENTARY:** Bruising, Dry skin, Itching, Lumps, Skin Cancer, Staph infection.

**CARDIOVASCULAR:** Cardiac history, Chest Pain, Hypertension, Murmur, Palpitations

**CONSTITUTIONAL:** Fatigue, Fever, Chronic Fatigue, Malaise, Muscle aches, Weight change.

**HEMATOLOGIC / LYMPHATIC:** Anemia, Bleeding skin, Hepatitis, HIV, Lymph Node, Lymphatic Malignancy: Hodgkins-Leukemia Acute Lymphocytic- Leukemia Acute Myelogeneous- Leukemia Chronic Lymphocytic- Non Hodgkin's Lymphoma.

Please check any of the following conditions you Currently have or Have had.

**Does not apply (Y / N)**

**Auto Injury (Y / N) Date**

**ILLNESSES** **DATE**

**SIGNS & SYMPTOMS**

- Abdominal; Pain
- Cough
- Dizziness
- Headache
- Insomnia
- Malaise (Fatigue)

**ARTERIAL**

- Atherosclerosis
- Peripheral Vascular Disease
- Other: \_\_\_\_\_
- Aortic or Abdominal Aneurysms

**HEART DISEASE**

- Congestive Heart Failure
- Hypertension
- Other: \_\_\_\_\_

**CEREBROVASCULAR**

- Aneurysms \_\_\_\_\_
- Carotid Artery Disease
- Stroke
- Other: \_\_\_\_\_

**CONGENITAL ANOMALIES**

**CONNECTIVE TISSUE**

- Arthritis Juvenile Rheumatoid, Psoriatic, Rheumatoid
- Lupus
- Osteoarthritis

**ENDOCRINE**

- Diabetes Type I / II
- Gout
- Hyperthyroidism (Graves disease)
- Hypothyroidism

**EAR/MOUTH/NOSE/THROAT**

- Menieres
- Tinnitus (Ringing)
- TMJ
- Other: \_\_\_\_\_

**EYE:** Other: \_\_\_\_\_

**GASTROINTESTINAL**

- Colon
- Hernia
- Liver / Gall Bladder
- Pancreas
- Stomach
- ( Chrons /Diverticulitis / IBS)
- Other: \_\_\_\_\_

**GENITOURINARY**

- Other: \_\_\_\_\_

**HEMATOLOGY**

- Coagulation Defect
- Other: \_\_\_\_\_

**INFECTIOUS DISEASE**

**SKIN/INTEGUMENT**

- Skin Cancer
- Other: \_\_\_\_\_

**LUNG (Respiratory)**

- Asthma
- Emphysema
- Other: \_\_\_\_\_

**MUSCULOSKELETAL**

- Frozen Shoulder (Adhesive Capsulitis)
- Ankylosing Spondylitis
- Back Pain
- Bursitis: Where \_\_\_\_\_
- Dislocation
- Epicondylitis
- Fracture: What \_\_\_\_\_
- Herniated disc
- Muscle spasm
- Osteochondritis Dessicans
- Osteoporosis
- Plantar Fascitis
- Radicular Neuropathy
- Rotator Cuff Syndrome
- Sciatica
- Scoliosis
- Spinal Stenosis
- Spondylolithesis
- Tendonitis: Where \_\_\_\_\_
- Torticollis

**NEOPLASM'S**

- Cancer/Chemotherapy/ Radiation

**NEUROLOGY**

- Bell's Palsy
- Carpal Tunnel
- Headache – Cluster –
  - Migraine
- Parkinson's
- Other: \_\_\_\_\_

**PSYCHIATRY**

- Attention Deficit Disorder
- Depression
- Drug dependency
- Manic Depressive
- Other: \_\_\_\_\_

**INJURIES** **DATE**

- Back Injury
- Falls/Fracture (What)
- Head Injury Joint Injury
- Motor Vehicle Accident (When)
- Soft Tissue Injury

**SURGERIES** **DATE**

- None
- Breast
- Cardiovascular
- Gastrointestinal
- Musculoskeletal
- Carpal Tunnel L/R
- Spinal (Neck/Back)
- Shoulder L/R
- Knee L/R
- Hip L/R
- Other: \_\_\_\_\_

**TREATMENTS** **DATE**

- Chiropractic Doctor: \_\_\_\_\_
- Physical Therapy: \_\_\_\_\_

**PREVENTITIVE**

- Mammogram Performed? Y/N Date: \_\_\_\_\_
- Bone Density Date: \_\_\_\_\_
- Colonoscopy Date: \_\_\_\_\_

**OB/GYN**

- Pregnant? Y / N
- DUE DATE: \_\_\_\_\_

## 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 describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

### Use and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our 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, pay your health care bills, to support the operations 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 health care 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 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, marketing, and fund raising activities, and conduction 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 included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you 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.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

## Back & Neck Care Chiropractic Financial Policies

Michael Pettet, DC Jeffrey Melin, DC 11516 SE Mill Plain Blvd, Ste 2C, Vancouver, WA 98684 P: 360-253-6674 F: 360-253-8670  
www.pettetchiro.com

### Insurance Coverage:

Welcome to *Back & Neck Care Chiropractic, Acupuncture, & Sports Massage*. Your insurance policy is an agreement between you and your insurer, not between your insurer and this clinic. Like all types of care, coverage for chiropractic, acupuncture and massage services varies from insurer to insurer, and plan to plan. Most insurance policies require the beneficiary to pay a co-insurance, co-payment, and/or deductible. Our clinic will call your insurer to verify your benefits; however, we are not responsible for your insurer's final payment and benefit determinations. If we are unable to verify your insurance, you are responsible for our first visit fee, until your portion is verified. After insurance verification, if we have overestimated your responsibility, you will have a credit on file; if we have underestimated your portion, the first visit fee helps you avoid being behind on your account, or receiving a surprise bill in the mail.

### Payments:

In order to help you determine your responsibility toward payment for services, please read the following, and initial your preference for the method of payment of your account. Please notify the office immediately if the status of your insurance has changed. First visit charges are expected to be paid prior to your first visit. We accept cash, check or credit card.

\_\_\_ **Option 1: Time of Service**—As I have no insurance, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered.

\_\_\_ **Option 2: Health Insurance**—I would like this clinic to bill my health insurance. I understand I am ultimately responsible for all costs of treatment. Additionally, not all services are covered by insurance. We will make every attempt to inform you of non-covered services so that you can make an informed decision; however, you are still responsible for paying for all services rendered.

\_\_\_ **Option 3: Worker's Compensation**—I would like this clinic to bill the Department of Labor & Industries (L&I)/or another responsible party. I understand I am responsible for reporting my accident to my employer, and for providing our office with the necessary insurance information, and completed Accident Report for L&I. Until this aforementioned information is provided, OR if the claim is denied I am required to pay for my care out of pocket. Approved Worker's Compensation claims are not required to pay for care as it is rendered. Transfer of Care claims will be verified with the claims manager. Reopening of claims closed past 90 days will require me to make personal arrangements for payment, and will be reimbursed if claim is allowed.

\_\_\_ **Option 4: Personal Injury**—I would like this clinic to bill my auto insurance, third party auto insurance, or personal injury claim. I understand I need to provide our office with the accident report, auto insurance, health insurance, and attorney, if applicable. If the claim is a possible third party liability, I am responsible for providing the other parties' insurance carrier information, as well as retaining an attorney Letter of Protection, in order to be seen in our office. Until necessary insurance information is gathered and verified for chiropractic care, you will be required to pay for your care on a cash basis. Patients with approved personal injury claims are not required to pay for care as it is rendered.

### Missed Visit Policy:

It is the policy of *Back & Neck Care Chiropractic, Acupuncture, & Sports Massage* to assess a \$30 missed visit fee to patients who cancel massage and acupuncture appointments with less than 24 hour notice. One missed visit will not result in the assessment of the fee, but you will be charged for any additional missed visits. This clinic provides care for many individuals and missed visits result in time lost that could have been used to provide care for others.

My initials here indicate that I have read and understand the Missed Visit Policy.

*Notice: If your account becomes PAST DUE, and we have had no contact with you in over 90 days, your account will be sent to our collection agency. Every effort will be made to work with you to avoid this.*

I understand and agree to the Financial Policies of *Back & Neck Care Chiropractic, Acupuncture & Sports Massage*

Signature of Patient or Representative: \_\_\_\_\_

Date: \_\_\_\_\_



11516 SE Mill Plain Blvd. #2C  
Vancouver, WA 98684  
Phone: (360) 253-6674  
Fax: (360) 253-8670

**Assignment of Patient Rights & Benefits**

Name: \_\_\_\_\_ Claim or Member ID/Group Number: \_\_\_\_\_

I hereby instruct and direct \_\_\_\_\_ Insurance Company to pay by check made out  
(Name of Insurance Company to be billed)  
and mailed to:

Back & Neck Care Chiropractic  
11516 SE Mill Plain Blvd, Ste 2C  
Vancouver, WA 98684

Or

If my current policy prohibits direct payment to the doctor, I hereby also instruct and direct you to make out the check to me as follows: \_\_\_\_\_  
(Full Legal Name)

For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
Signature of Policyholder  
Signature of Claimant, if other than Policyholder

\_\_\_\_\_  
Witness