QUEEN ANNE chiropractic CENTER | PATIENT INTRODUCTION FORM & CLINICAL RECORD

GENERAL INFORMATION **TODAY'S DATE:** _____

Full Name _____ Preferred name _____

Address _____

City _____ State _____ Zip Code _____

Phone: Home _____ Work _____ Cell/Other _____

Employer _____ Occupation _____

SS# _____-_____-_____ Birthdate _____/_____/_____ Age _____ ☐ Male ☐ Female

E-mail _____ Spouse/Partner's Name _____

Referred by: Friend _____ ☐ Walk-in ☐ Insurance ☐ Dr ☐ Yellow Pages ☐ Other _____

REASON FOR VISIT **What date did this condition begin?** _____

What is the reason for this visit? ☐Work ☐Auto Accident ☐Trauma ☐Sports ☐ Other _____

Please describe the pain and its location: _____

_____

Is this condition getting worse? ☐Yes ☐No ☐ Constant ☐ Comes & Goes ☐ Other _____

At what times does this condition affect you the most? **Please check all that apply.**

☐ Work ☐ Sleep ☐ Sitting ☐ Standing ☐ Daily Routine ☐ Other _____

Have you had this or a similar condition this past? ☐Yes ☐No If yes, please explain. _____

_____

Have you been treated by a MD for this condition? ☐Yes ☐No If yes, please list:

Doctor: _____ Location: _____ Phone number: _____

Have you been adjusted by a chiropractor before? ☐Yes ☐No If yes, please list:

Chiropractor _____ Location: _____ Phone number: _____

MEDICAL INFORMATION **Please check the disease/health condition you have experienced below.**

____ Alcohol/Drug Abuse
____ Anemia
____ Arthritis
____ Artificial Bones/Joints
____ Asthma
____ Back Surgery
____ Cancer
____ Cold Sweats
____ Cold Hands &/Feet
____ Constipation
____ Depression
____ Diabetes
____ Dizziness
____ Fatigue
____ Hay Fever
____ Heart Attack/Stroke
____ Heart Pain
____ Heart Palpitations
____ Heart Surgery/Pacemaker
____ Hepatitis
____ High/Low Blood Pressure
____ HIV+/AIDS
____ Kidney Problems
____ Liver Trouble
____ Loss of Balance
____ Memory Loss
____ Menstrual Cramps/Pain
____ Neck Muscle Spasms
____ Neck Pain
____ Nervousness
____ Painful Joints
____ Pins & Needles in Arms & Hands
____ Pins & Needles in Legs
____ Pain in Legs & Feet
____ Psychiatric Problems
____ Rheumatic Fever
____ Ringing in Ears
____ Seizures/Epilepsy
____ Severe/Frequent Headaches
____ Shingles
____ Sinus Problems
____ Sleeping Problems
____ Stomach Problems/Indigestion
____ T.B. Gall Bladder
____ Tightness of Shoulder Muscles
____ Ulcers
____ Venereal Disease

Please list any other past or continuing serious health condition(s) with month & year this began:

_____

Have you ever had surgery? ☐Yes ☐No If yes, please list surgery with month & year this began: _____

_____

Are you presently taking medication? ☐Yes ☐No If yes, please list type, dosage & what it is for: _____

_____

Do you smoke? ☐Yes ☐No If yes, how much? _____ How long? _____ What is the age of your mattress? _____ Is it comfortable? ☐Yes ☐No

FOR WOMEN: Taking Birth Control ? ☐Yes ☐No Are you pregnant? ☐Yes ☐No If yes, how many months? _____ Are you nursing? ☐Yes ☐ No

AUTHORIZATION

The best services are based on a friendly mutual understanding between doctor and patient. We invite you to discuss with us any questions regarding our services.

- I authorize the staff to perform any necessary services needed during the course of my care.
- I also authorize the doctor to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge.
- I understand that it is my responsibility to inform the staff of any changes in my health status.

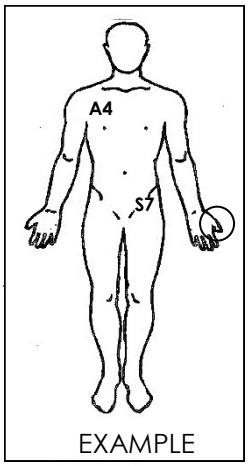
_____ _____

Signature Date

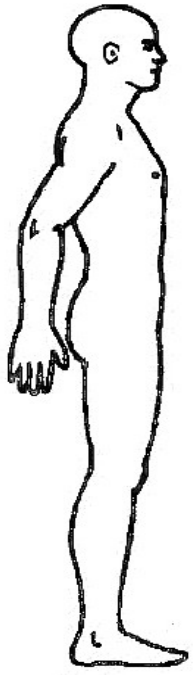
chiropractic QUEEN ANNE CENTER | **PATIENT NAME** _____ | SHOW US WHERE IT HURTS

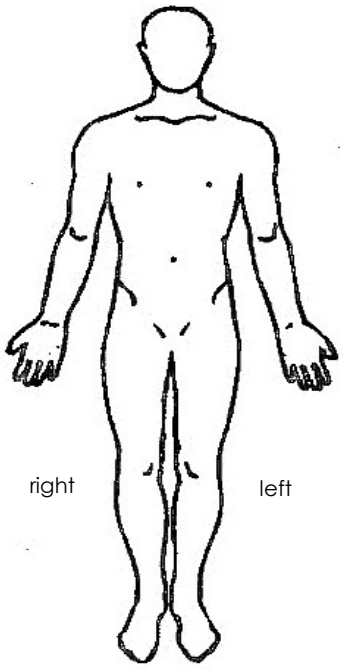
1. Please mark any area(s) of injury or discomfort as shown in the boxed example with the appropriate symbols and degree of pain.
2. Be sure to circle any area of pain not represented by the symbols below.

DESCRIPTION	Numbness	Pins & Needles	Burning	Aching	Stabbing
SYMBOL	N	P	B	A	S
PAIN LEVEL	1 (discomfort) to 10 (extreme pain)				

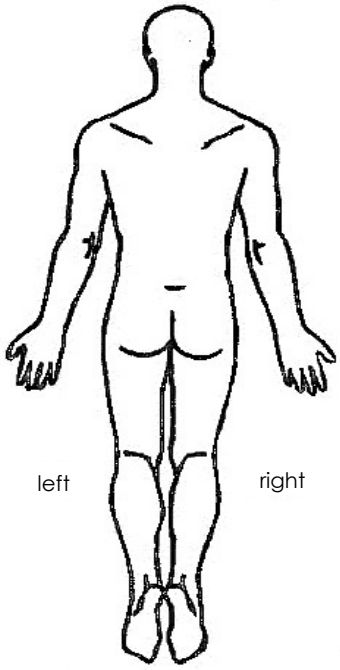


EXAMPLE

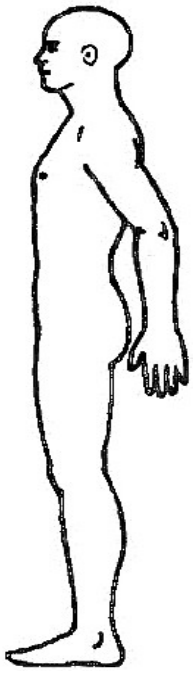

RIGHT



FRONT



BACK


LEFT

QUEEN ANNE CHIROPRACTIC CENTER FEE OUTLINE*

Consultation:	No charge
Chiropractic Examination:	$80-$200
Chiropractic Office Visits:	$50-$65
Chiropractic X-Ray Studies:	$100-$300

*All fees are standard and based on our professional association's guidelines.

QUEEN ANNE CHIROPRACTIC PLAN OPTIONS

Our experience has shown that it is wise for our patients to have a clear understanding of our office policies and fees. Please carefully read and select the plan you prefer. This information will enable us to better serve you and avoid any future misunderstandings. If special arrangements are necessary, please consult with our Office manager. Our main concern is your health and well being, and we will do our best to assist you.

OPTION 1: INSURANCE/MEDICARE

If you have insurance that covers Chiropractic Care, we will bill your insurance directly. Please bring us your insurance card on/by your second visit. Until we have completed the necessary insurance information to verify chiropractic coverage, you will be required to pay for your care. If the insurance check should come to you, you are expected to bring the check to us. Please understand that insurance is <u>your</u> responsibility. We will assist you in any way possible, but we cannot be responsible for plan changes. Any credit on your account will be applied to future visits only.

OPTION 2: CASH

Fees are to be paid at the time of the service.

OPTION 3: MONTHLY AGREEMENT

For those non-transient patients who qualify, we will extend knowledgeable credit through this plan. However, should you become inactive by discontinuing your care, your entire unpaid balance will be due immediately. This plan applies to all cases except work injury or auto/personal injury claims.

OPTION 4: CASH PREPAY

Please ask about the Annual Chiropractic Care Plan.

OPTION 5: WORK INJURY

You need to report your accident to your employer, bring in the necessary insurance information , and sign industrial forms for billing by your second visit. Until necessary insurance information is gathered and verified for chiropractic care, *you will be required to pay for your care*. We will bill your insurance directly upon verification of coverage. If the insurance check should come to you, you are expected to bring the check to us. Any credit on your account will be applied to future visits.

OPTION 6: PERSONAL/AUTO INJURY

You will need to supply us with the accident report, <u>*your*</u> car insurance (PIP), health insurance, liable party's insurance, and an attorney if applicable. Until necessary insurance information is gathered and verified for chiropractic care, *you will be required to pay for your care*. We will bill your insurance directly upon verification of coverage. If the insurance check should come to you, you are expected to bring the check to us. Any credit on your account will be applied to future visits.

Plan # _____ best suits my chiropractic needs. **Signature:** _____ **Date:** _____

QUEEN ANNE chiropractic CENTER

HIPAA AUTHORIZATION

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at QUEEN ANNE CHIROPRACTIC CENTER, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment, or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer (if they are or may be responsible for the payment of your services).
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, to provide information about alternatives to your present care, or to other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. However, if you do not provide us with this authorization, it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances if:

- we are providing health care services to you based on the orders of another health care provider.
- we provide health care services to you in an emergency.
- we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as described in the examples outlined above, will only be made upon your written authorization.

We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or the information in a different form, please advise us in writing with your preferences.

You have the right to inspect and/or copy your health information for seven years from the date the record was created or for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy, or amend your health related information should be provided to us in writing.

We are required by state and federal law to:

- maintain the privacy of your patient file and the health protected health information therein
- provide you with this notice of our privacy practices with respect to your health information
- abide by the terms of this notice while it is in effect

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files. Information that we use or disclose may be subject to re-disclosure by the person or persons to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices, or any aspect of our privacy activities, direct your complaint to: Darrell Gibson, D.C. (206) 282-8275. If you would like further information about our privacy policies and practices, please contact: Darrell Gibson, D.C. (206) 282-8275.

THIS NOTICE IS EFFECTIVE AS OF APRIL 14,2003. THIS NOTICE, AND ANY ALTERATIONS OR AMENDMENTS MADE HERETO, WILL EXPIRE SEVEN YEARS AFTER THE DATE UPON WHICH THE RECORD WAS CREATED. A COPY OF THIS NOTICE IS AVAILABLE UPON REQUEST.

_____	_____	_____
Name (Printed)	Signature	Date

If you are a minor or being represented by another party

_____	_____	_____
Personal Representative (Printed)	Personal Representative Signature	Date

_____

Description of the authority to act on behalf of the patient.

Queen Anne Chiropractic Center

Text and Email Appointment Reminders / Check-Ins

Name:

I would like to receive:

○ **Text Reminders**

My mobile telephone number is: (_____) _____ - _____

My mobile carrier is: ____ AT&T ____ T-Mobile ____ Verizon ____ Sprint

Other carrier: _____

○ **Email Reminders:** My email address is:

- I acknowledge that Text and Email messages are for appointment reminders and check-ins only. No medical advice or other patient information may be transmitted through these channels.
- By selecting Text reminders I acknowledge I have a messaging / text plan through one of the providers above and assume all charges that may incur on my telephone if I do not have a messaging plan.
- I understand Queen Anne Chiropractic Center will not share my email or telephone number with anyone.
- I understand I can opt-out of Text and Email reminders at any time.

_____

Signature

_____

Date