

Is this a work related injury? YES NO

When did your present complaints occur? _____

Who has treated you for this condition (if anyone)? _____

Is this condition interfering with your Work Sleep Recreation Dates missed: _____

Have you had this condition or similar conditions in the past? YES NO If so, when? _____

What treatment did you receive? _____

Name & location of previous chiropractor? _____

Approximate date of last chiropractic treatment: _____

If any of the following have happened to you, give approximate dates & briefly describe injury:

Auto Accidents: _____

Motorcycle accidents: _____

Falls or other injuries: _____

Spinal or neck injuries: _____

Broken bones: _____

Knocked unconscious: _____

Surgeries: _____

Health problems of parents: _____

Please check any of the following that apply to your current/past medical history:

- | | | |
|--|---|--|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Spinal curvature | <input type="checkbox"/> Gallbladder trouble |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Fainting | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Swollen ankles or legs | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Foot trouble | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Allergies | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Asthma | <input type="checkbox"/> Loss of sleep |
| <input type="checkbox"/> Ankle Pain | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Numbness in legs or feet | <input type="checkbox"/> Convulsions | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Numbness in arms or hands | <input type="checkbox"/> Arm pain | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Painful Joints | <input type="checkbox"/> Loss of weight | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Headaches / migraines | <input type="checkbox"/> Hardening of arteries | <input type="checkbox"/> Tumor |
| <input type="checkbox"/> Pain between shoulders | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Rapid heart beat |
| <input type="checkbox"/> Weakness in legs | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart attack |
| <input type="checkbox"/> Sprained Ankle | <input type="checkbox"/> Stroke | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Painful tailbone | <input type="checkbox"/> Blood in urine | |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Gout | |
| <input type="checkbox"/> Weakness in arms | <input type="checkbox"/> Colon trouble | |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tuberculosis | |
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> Hiatal hernia | |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Prostate trouble | |

For Women Only:

- Premenstrual tension
- Menopausal symptoms
- Lumps in breast
- Tubal ligation
- Unable to get pregnant
- Menstrual cramps
- Irregular cycle
- Hysterectomy

Is there a possibility that you may be pregnant?

YES NO

Date of last menstrual period

I authorize treatment of the person named above and agree to pay all fees for such treatment. I hereby authorize Wellness for Life Chiropractic to receive all benefits to which I or my dependents are entitled to under my health insurance plan. I agree that I will not withhold or delay payment if my insurance company denies payment on any of my charges. The undersigned agrees that whether he/she signs as an agent that he/she is obligated to pay for the account. Should the account exceed an amount that the undersigned is unable to pay in full, agreed upon payments by the undersigned and the clinic can be established with a 1% interest per month (RCW 19.52) on the unpaid balance. Should the account be referred to collections, the undersigned, or their agent, will be responsible for payment of interest on the unpaid balance at 1% per month from the date of service, collection fees, reasonable attorney fees and court costs. I have also been informed of the \$25.00 fee (per RCW62A,3-515 &520) on a check returned NSF.

Patient Signature _____ Date _____

(If a minor) Guardian 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 be used 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 vertebra 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 another health care provider.

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 subluxations.

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)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of
_____ have read and fully understand the above terms of
acceptance and hereby grant permission for my child to receive chiropractic care.

(Parent or Guardian signature)

(date)

Wellness for Life Chiropractic

6700 15th Ave NW
Seattle, WA 98117
206-784-3494

Notice of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), 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 multiple healthcare providers who may be involved, in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Practice Practices containing a more complete description of the uses and disclosures of my health information. I understand that this practice has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Signature: _____

Relationship if other than patient: _____

Date: _____

FOR OFFICE STAFF ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date: _____

Reason: _____

Name: _____

Notice of Privacy Practices

This notice describes how medical information about you may be used, disclosed and how you can get access to this information.

Please review it carefully

The Health Insurance Portability and Accountability Act of 1996 HIPAA is a Federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form; whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may disclose your medical record only for each of the following purposes: **Treatment, payment and health care operations.**

- **Treatment** means providing coordinating or managing health care and related services by one or more health care providers. Examples of this would include your primary care physician, physical or massage therapist, etc.
- **Payment** means such activities as obtaining reimbursement for services, confirming converge, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be internal quality assessment review.

We may also create and distribute the identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken action relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer to be forwarded to medical records.

- The right to request restrictions on certain uses and disclosures of protected health information including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in affect. We reserve the rights to change the terms of our *Notice of Privacy Practices* and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised *Notice of Privacy Practices* from this office.

You have recourse if you feel your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights about violations of the provisions of this notice. We will not retaliate against you for filing a complaint.

Please feel free to contact us for more information.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights

200 Independence Avenue SW

Washington, DC 20201

(202) 619-0257 Toll Free; (877) 696-6775