

Healthy Life Chiropractic

Confidential Patient Information

Date: _____

Name: _____ D.O.B. _____ SSN: ___ - ___ - _____ Sex: M F
(First) (Mi) (Last)

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Home Address: _____
(Street) (City) (Zip)

Employed by: _____ Location: _____ Work Phone: _____

Fax: _____ Occupation: _____ Email Address: _____

If patient is a minor, who is responsible for this account? Relationship to patient: _____

Emergency Contact Information:

1. Name: _____ Phone: _____ Relationship: _____
2. Name: _____ Phone: _____ Relationship: _____

Who referred you to our office? _____

Is your visit due to an accident? No Yes (If yes, Please see receptionist for an injury report.)

Have you or your family had chiropractic care in the past? _____ As a child/adult? _____

If so, what conditions were you treated for? _____

The names of other doctors seen for this condition: _____ When _____

Have you been treated by a physician for any health condition in the last year? Yes No

Describe Condition(s) _____ Date of last Physical Exam: _____

Date of last Spinal X-Rays: _____ Dr. or Office name _____ Phone # _____

Are you currently taking any medications? Yes No. If yes Please list: _____

Are you allergic to any medications? Yes No. Please list: _____

Are you pregnant? Yes No Date of last menstrual period _____

Health Insurance Information – A copy of insurance card is required to be on file.

(1) Primary Insurance: _____ ID Number: _____ Group: _____
(2) Secondary Insurance: _____ ID Number: _____ Group: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account.

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if Healthy Life Chiropractic extends credit to me and I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made.

I hereby authorize the doctors at Healthy Life Chiropractic and whomever they may designate as their assistants to administer treatment as they so deem necessary. I authorize the release of any information in the course of my examination or treatment required by my insurance company for the purpose of billing. I certify that the above information is true and correct.

Patient's Signature: _____ Date: _____

Parent or Guardian's Signature: _____ Date: _____

HEALTH HISTORY REPORT

NAME: _____

Have you ever experienced any of the following conditions? Please use "C" for Current and "P" for Past.

Doctor's Notes:

_____ HEADACHES	_____
_____ DIZZINESS	_____
_____ BLURRED VISION	_____
_____ BUZZ/RINGING IN EAR	_____
_____ SINUS PROBLEMS	_____
_____ LOSS OF CONCENTRATION	_____
_____ FAINTING	_____
_____ NECK PAIN/STIFFNESS	_____
_____ SHOULDER PAIN	_____
_____ ARM PAIN	_____
_____ UPPER BACK PAIN	_____
_____ MID BACK PAIN	_____
_____ LOW BACK PAIN	_____
_____ HIP PAIN	_____
_____ LEG PAIN	_____
_____ DEPRESSION	_____
_____ LOSS OF ENERGY	_____
_____ DIFFICULTY SLEEPING	_____
_____ HEART PALPITATIONS	_____
_____ CHEST PAIN	_____
_____ POOR CIRCULATION	_____
_____ SWOLLEN JOINTS	_____

Have you ever experienced general problems with the following? Please use "C" for Current and "P" for Past.

_____ STOMACH	_____
_____ DIGESTION	_____
_____ BLADDER	_____
_____ LIVER	_____
_____ KIDNEYS	_____
_____ COLON	_____

Previous injuries? If yes, please briefly explain

_____ HOSPITAL/SURGERY (YES/NO)

_____ ACCIDENTS (AUTO/FALLS) (YES/NO)

_____ ACCIDENT ON JOB (YES/NO)

Family History **Mother's Side / Father's side**

_____ HEART DISEASE	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>
_____ ARTHRITIS	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>
_____ CANCER	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>
_____ DIABETES	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>
_____ OTHER: _____	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>

HEALTHY LIFE CHIROPRACTIC

PAIN LOCATION AND RATING SCALE

NAME: _____ DATE: _____

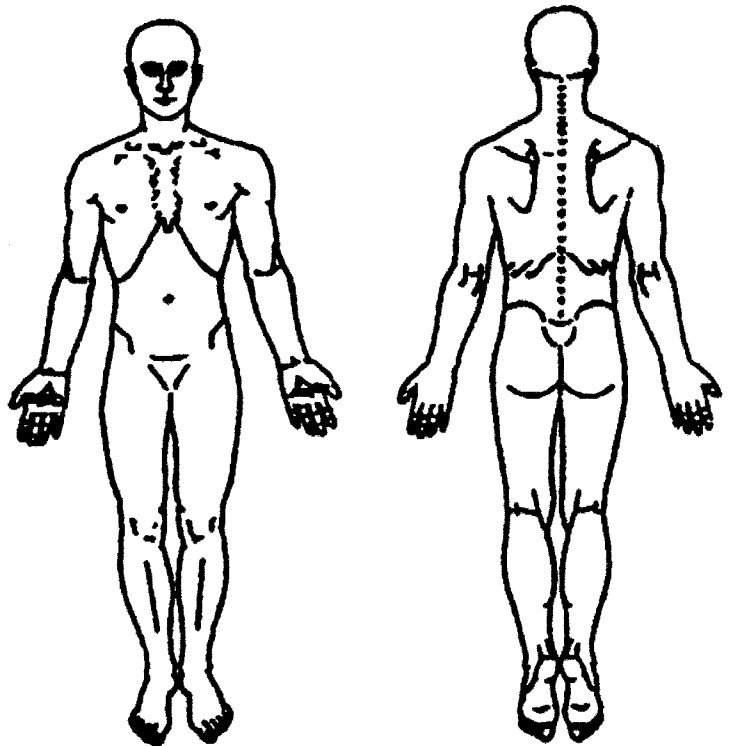
MY CHIEF COMPLAINT IS: _____

2ND COMPLAINT: _____

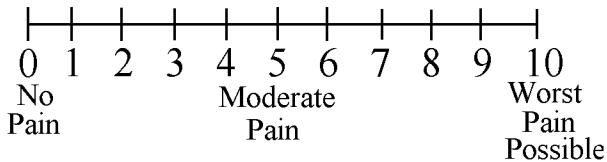
3RD COMPLAINT: _____

Using the legend below, please mark the letter that indicates the type of pain you are experiencing on the body outlines.

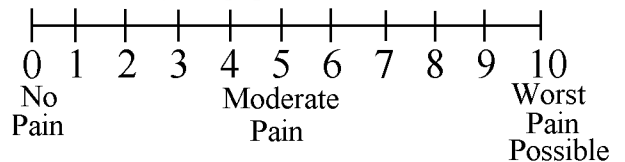
- A = Ache
- B = Burning
- S = Stabbing/Sharp
- N = Numbness
- T = Tingling
- X = Acute Pain
- O = Other



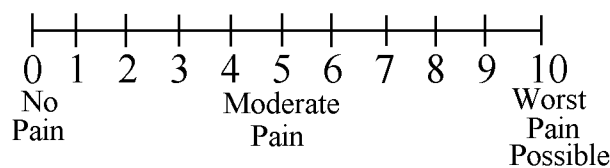
CHIEF COMPLAINT



2ND COMPLAINT



3RD COMPLAINT



Healthy Life Chiropractic Clinic Policies

Welcome to Healthy Life Chiropractic, the office of Dr. Kari Gibson. Your health is our number one priority! In an effort to make your experience here relaxing and positive, and to help us focus on regaining and maintaining your health we ask that you please take a moment to read over our clinic policies. We will be happy to answer any questions you may have regarding these policies, your account, or insurance coverage.

Patient Payment Policy

The following payment policy is an attempt to allow you, the patient, to receive the care you need while remaining current on any balance you may have for services rendered.

Initial Evaluation Fees

We require 25% of the first visit charges due on the first day of service. The balance of these charges may be made in payments over the next six weeks, unless we bill your insurance for payment. Properly documented Worker's Compensation and auto accident claims are not required to pay same day if appropriate forms and liens are signed.

Established Patient Care Services

Patients under care are required to make regular payments on all unpaid balances, except for properly documented Worker's Compensation or auto injury claims. Payments need to be paid monthly. We do charge 1% interest on all account balances over 60 days.

You will receive a monthly statement with all of your charges itemized. Please review these and retain them for your records (taxes, etc.) If you have questions regarding your statements or if you are missing a statement please contact our billing representative Raea Tomlin by email pure.billing@gmail.com or by phone 360-654-1476.

Health Insurance

Today most insurance policies do cover chiropractic care. 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 health insurance will or will not cover.

Copayments are due at time of service. Any additional balance is due within 30 days of the date of service.

Appointments

Your appointment time is reserved for you. Please be courteous and notify our office as soon as possible if you are unable to make it to your scheduled appointment time. Failure to notify us in a timely manner takes away our opportunity to help another patient. Notifying us quickly also increases your chance of rescheduling to a time that works best for you.

Goals of Healthcare

Healthy Life Chiropractic Clinic provides three types of care. The first is **Initial Intensive Care** which corrects the most recent insults to your spine and nervous system. This care usually reduces or eliminates the symptoms. The second phase is **Reconstructive Care** which corrects the years of damage that occurred when there were few symptoms. And finally, Chiropractic offers a genuine approach to **Wellness Care**. All of these options will be explained at your report of findings during your second office visit when you and your doctor review your x-rays and examination results. At this time you will begin a course of care that fits your health goals and needs.

Thank you for choosing Healthy Life Chiropractic. We look forward to helping you with your chiropractic needs.

Sincerely,

Healthy Life Chiropractic

I have read the Healthy Life Chiropractic Clinic Policies and will honor them:

Patient Signature

Date

HEALTHY LIFE CHIROPRACTIC CLINIC NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

Federal and state law requires us to maintain the privacy of your medical information. That law also requires us to give this notice about our privacy practices, legal duties, and your rights concerning your medical information. We must follow the privacy practices we describe in this notice and make the new notice available upon request.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such applicable law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all medical information that we created or received before we made the changes. Before we make a significant change in our privacy practices we will change this notice and make the new one available upon request.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use and disclose medical information about you for treatment, payment, and health care operation. For Example:

Treatment: We may use your medical information for treatment or disclosure to a chiropractor, physician, or another health care professional providing co-treatment to you.

Payment: We may use and disclose your medical information for healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, certification, licensing, and credentialing activities. We may disclose your medical information to another health care professional or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operation. We may disclose your medical information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or to detect or prevent health care fraud and abuse.

On your authorization: You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. You may revoke your authorization in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your medical information for any reason except those described in this notice.

To your family and friends: We may use or disclose your medical information to a family member, friend, or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your medical information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up medical supplies, x-rays, or other similar forms of medical information. We may use or disclose medical information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

Appointment Reminders: We may use or disclose your medical information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Disaster Relief: We may use or disclose your medical information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- As required by law; for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury.
- To report adult abuse, neglect, or domestic violence.
- To health oversight agencies
- In response to court and administrative orders and other lawful processes, to law enforcement officials pursuant to subpoena and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person.
- To an organ procurement organization.

- To avert a serious threat to health or safety
- In connection with certain research activities.
- To the military and to federal officials for lawful intelligence, counter intelligence, and national security activities.
- To correctional institutions regarding inmates.
- As authorized by state worker's compensation laws.

PATIENT RIGHTS

Access: You have the right to view or obtain copies of your medical information with limited exceptions. You must make your request in writing to obtain access to your medical information. You may request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge a cost-based fee that may include a labor copying cost and postage.

Disclosure Accounting: You have the right to receive a list of instance in which our business associates or we disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations authorized by you, and for certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to your additional requests. If you have any questions regarding fees please feel free to contact us.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to such additional restrictions, but if we do so agree, we will abide by our agreement (except in an emergency situation). Any agreement we make to request for additional restrictions must be in writing and signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing and signed by yourself and an authorized individual.

Amendment: You have the right to request that we amend your medical information. Your request must be in writing, and it must explain why we should amend the information. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have any concerns, please contact us.

If you believe that:

- We have violated your privacy rights
- We made an incorrect decision about access to your medical information
- Our response to a request you made to amend or restrict the use or disclosure of your medical information was incorrect
- We should communicate with you by alternative means

You may contact us at the address and phone number below. You may also submit a written complaint to the U.S. Department of Health and Human Services. If you do not have the correct information to file your complaint we will provide you with the address upon request. We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HEALTHY LIFE CHIROPRACTIC CLINIC
811 RAINIER STREET
SNOHOMISH, WA 98290
P: 360-568-8800 F: 360-568-0581

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays, on myself (or on the patient named below, for whom I am legally responsible: _____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the physician of chiropractic named here Dr. Kari Gibson and/or other licensed physicians of chiropractic whom may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Kari Gibson and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all health care, the practice of chiropractic carries some risks to treatment, including, but not limited to, fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect my physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of procedures which the physician feels are in my best interests, at the time, based upon the facts then known.

I have read or have read to me the above consent. I have also had an opportunity to ask questions about its contents. By signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment at this facility.

To be completed by the patient:

To be completed by the patients
Representative, if necessary,
(e.g. If the patient is a minor or is
physically or mentally incapacitated)

Patient's Name Printed

Patient's Name Printed

Signature of Patient

Signature of Representative

Patient Name: _____ Date: _____

AUTO ACCIDENT INFORMATION

Date and time of accident: _____ am pm
Were you the: Driver Front Passenger Rear Passenger
Make and Model of the vehicle you were occupying: _____
If a traffic violation was issued, to whom was it issued: _____
Number of people in accident vehicle: _____
Did the Police come to the accident site? Yes No
Was a police report filed? Yes No
Were there any witnesses? Yes No
Were you wearing a seatbelt? Yes No
Was this vehicle equipped with air bags? Yes No
If Yes, did they inflate Yes No
In relation to the base of your skull, where was the head rest? Above Below At base of skull
What did your vehicle impact? Another vehicle Other
If other, please explain: _____
Did any part of your body strike anything else in the vehicle? Yes No
If yes, please describe: _____
Name of the location / street on which you were traveling: _____
In which direction were you headed? N S E W
What was the approximate speed of your vehicle? _____ MPH
Did the impact to your vehicle occur on the: Front Rear Right Side Left Side Other
During impact were you facing: Right Left Forward
Were you: Aware it was going to happen Surprised by the impact
If accident vehicle made impact with another vehicle . . .
Direction other vehicle was headed: N S E W
Approximate speed of other vehicle: _____ MPH

In your words, please describe the accident:

Patient Name: _____ Date: _____

AFTER INJURY

Did the accident render you unconscious? Yes No

If yes, for how long? _____

Please describe how you felt immediately after the accident: _____

Have you been to a hospital or seen any other doctor regarding this accident? Yes No

When did you go? Immediately after the accident The next day 2 days or more after

How did you get there? Ambulance Private transportation

Name of hospital and/or doctor who treated you: _____

Was he/she a Chiropractor Medical Doctor Osteopath Dentist

Describe any treatment you received: _____

Were X-Rays taken? Yes No

Were you prescribed any medication? Yes No

Have you been able to work since this injury? Yes No

Are your work activities restricted as a result of this injury? Yes No

Please indicate any symptoms you are experiencing as a result of this accident:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Ringing in ear | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Stomach upset |
| <input type="checkbox"/> Memory loss | <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Stiff neck | <input type="checkbox"/> Hip or leg pain |
| <input type="checkbox"/> Headache(s) | <input type="checkbox"/> Irritability | <input type="checkbox"/> Jaw problems | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Arm/shoulder pain | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Buzzing in ear | <input type="checkbox"/> Tension | <input type="checkbox"/> Numb hands/fingers | <input type="checkbox"/> Back stiffness |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Nausea | <input type="checkbox"/> Numb feet/toes | |

Other _____

Is your condition getting worse? Yes No

Is your pain/discomfort : Constant Comes and goes

Patient Name: _____ Date: _____

Please indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on side.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on stomach.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stretching.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lovemaking.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you retained an attorney? Yes No

If yes, whom? _____

His/her phone #: _____

RECOVERY

How many hours are in your normal work day? _____

Please indicate any of the following tasks you are occasionally asked to perform at your daily job:

Standing Driving Typing Other _____

Sitting Twisting Stooping

Walking Crawling Operating equipment

Lifting Bending Work with arms above head

What positions can you work in with minimal physical effort and for how long? _____

Patient Name: _____ Date: _____

Prior to your injury were you capable of working on an equal basis with others your age? Yes No NA

Do you work with others who can help you with any heavy lifting? Yes No NA

While in recovery, is there any light duty work you may request? Yes No NA

I guarantee this form was completed to the best of my knowledge and I understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ____/____/____

Adult patient Parent or Guardian Spouse

PIP Billing

What is PIP?

- Personal Injury Protection is a part of your auto insurance policy. It is designed to take care of you immediately after an accident.

Benefits of PIP.:

- PIP is no-fault, so it doesn't matter who caused the accident. You're still covered.
- Most PIP coverage is for one year or \$10,000, whichever comes first. Some policies have higher limits.
- PIP covers medical payments, wage loss, and loss of services. There is no deductible.

What is Med Pay?

- Med Pay is a medical-payments-only version of PIP. It does not cover wage loss or loss of services.

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A Step-By-Step Guide:

1. Call your Insurance agent.
2. Ask if you have PIP or Med Pay
3. If yes, ask about limits on time and dollar amount.
4. Ask your agent to take your report of loss and call it into the claims office.
5. Ask your agent to call back with the claim number, address and the phone number of the claims office.
6. Call the claims office and get the name of the claims adjuster handling your claim.
7. Ask the claims adjuster to mail a PIP Application, Attending Physician's Report and Salary Verification forms to you.
8. Complete the PIP Application and return it to the claims adjuster.
9. Have your doctor fill out the Attending Physician's Report form and return it to you. Mail it to the claims adjuster.
10. Provide your claim number and the adjuster's name, office address and phone number in the space provided below.

Don't Panic! If you have any questions do not hesitate to ask. We are happy to help you!

Name of your Insurance Company: _____

Claim Number: _____

Adjuster's Name: _____ **Phone Number:** _____

Insurance Co. Address: _____