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	☐	☐
ARTHRITIS	☐	☐
CANCER	☐	☐
DIABETES	☐	☐
OTHER:__________________	☐	☐

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

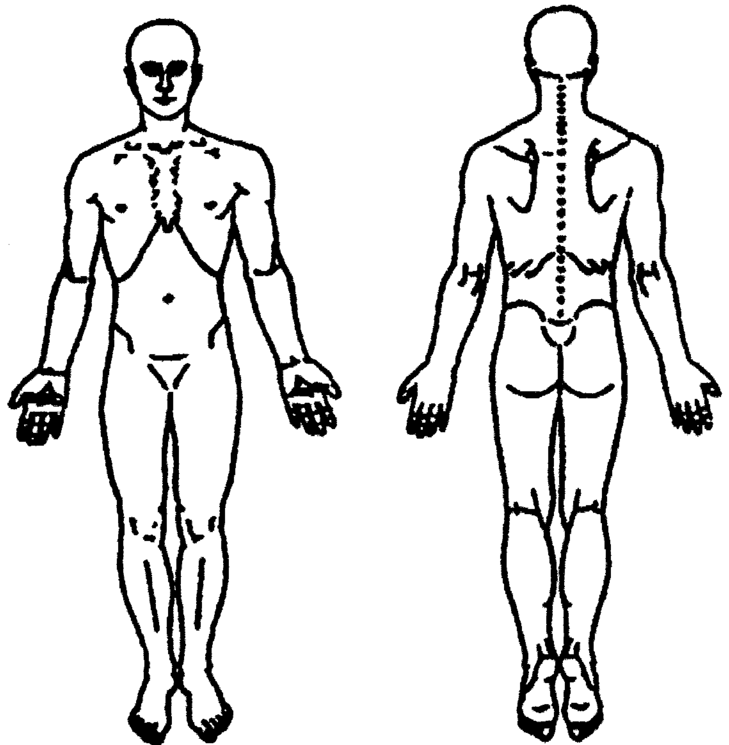
S = Stabbing/Sharp

N = Numbness

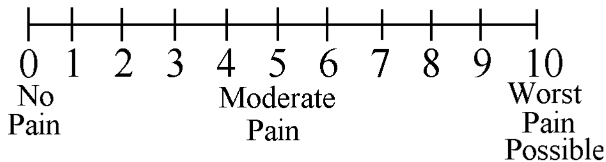
T = Tingling

X = Acute Pain

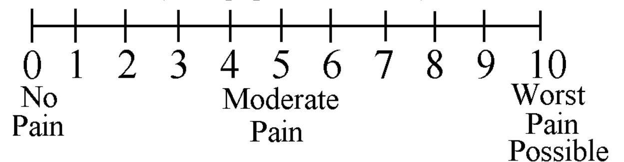
O = Other



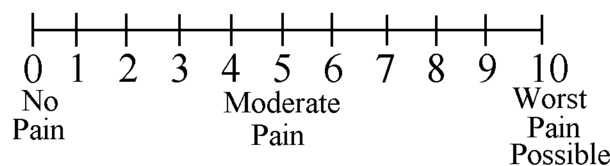
CHIEF COMPLAINT



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:

____
Patient's Name Printed

____
Signature of 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

____
Signature of Representative

Healthy Life Chiropractic

Date: __________

I, ____________________________, have received a copy of the Notice of Privacy Practices from Healthy Life Chiropractic Clinic. I understand that if I have any questions regarding this notice I am to contact Healthy Life Chiropractic Clinic.

____
Patient Signature

811 Rainier Street – Snohomish, WA 98290
P: 360-568-8800 F: 360-568-0581

Patient Name: ____ Date: __________

WORKERS COMPENSATION INFORMATION

Date and time of accident: ______________________ □ am □ pm
Was your accident directly related to your work? □ Yes □ No
Briefly describe the events that occurred just before and during your accident: ____________________
____

Address where the accident occurred: (if other than employer's address) ________________________
____

Was anyone else present during your accident? □ Yes □ No
Did you report your accident to your employer? □ Yes □ No
What recommendations did your employer make just after your accident? _______________________
____

Has this type of accident happened to you before? □ Yes □ No
To the best of your knowledge, has this type of accident occurred at your workplace before?□ Yes □ No

In general:
Is your job physically stressful? □ Yes □ No
Is your job mentally stressful? □ Yes □ No
Is your workplace very noisy? □ Yes □ No
Have you changed jobs in the last year? □ Yes □ No

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
If yes, when? □ Immediately after the accident □ The next day □ 2 days plus
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 Medications? □ Yes □ No If yes, please list: _________________________
Have you been able to work since this injury? □ Yes □ No
Are your work activities restricted as a result of this injury? □ Yes □ No

Patient Name: ____ Date: __________

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

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

□ Other ____
____

Is your condition getting worse? □ Yes □ No

Is your pain/discomfort: □ Constant □ Comes and goes

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

	Comfortable	Uncomfortable	Painful
Lying on back ………………………………..	□	□	□
Lying on side……………………………….	□	□	□
Lying on stomach…………………………..	□	□	□
Sitting………………………………………	□	□	□
Standing…………………………………….	□	□	□
Stretching……………………………………	□	□	□
Lovemaking………………………………....	□	□	□
Walking…………………………………….	□	□	□
Running…………………………………….	□	□	□
Sports……………………………………….	□	□	□
Working…………………………………….	□	□	□
Lifting………………………………………	□	□	□
Bending……………………………………..	□	□	□
Kneeling………………………………….....	□	□	□
Pulling………………………………………	□	□	□
Reaching…………………………………....	□	□	□

Have you retained an attorney? □ Yes □ No
If yes, whom? ____
His/her phone #: ____

Patient Name: ____ Date: __________

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? __________________

____

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