BATTLE GROUND CHIROPRACTIC, PS * 1710 W Main St, STE 101 * Battle Ground, WA 98604 * (360)687-3181 * (360)687-1992/fax

BATTLE GROUND CHIROPRACTIC

CONFIDENTIAL PATIENT HEALTH INFORMATION FORM

PERSONAL INFORMATION

Patient Legal Name_____ Nickname_____

Mailing Address_____ Birth Date_____ Age_____

City_____ State_____ Zip_____-_____ Gender: ☐ Male ☐ Female

E-mail_____ Home # ( )_____

Occupation_____ Work # ( )_____

Employer_____ Cell # ( )_____

In what order would you like to be called if necessary? ☐ Home ☐ Work ☐ Cell

Marital Status: ☐ Married ☐ Other ☐ Single

Who is your family doctor (PCP)/Clinic?_____

If the patient is a minor, I hereby authorize the doctors/therapists to administer chiropractic and/or massage care as they deem necessary to my _____ (indicate relationship of child). I authorize the doctor to order x-rays if clinically necessary and verify that this minor, if female, is not pregnant.

_____ Guardian or Authorized Representative's Name (Please Print)

_____ Witness Name/Title (Please Print)

_____ Guardian or Authorized Representative's Signature

_____ Witness Signature

FINANCIAL AGREEMENT / CONSENT TO TREAT

Although you are ultimately responsible for your bill, we will file your insurance claim for you and make reasonable attempts to secure payment if you provide us with complete insurance information.

☐ I am certain I have no insurance coverage for these services; I will pay directly for these services.

☐ I have provided you with my insurance card for scanning. ***Complete the following if patient is not subscriber***.

	Primary Insurance	Secondary Insurance
Insurance Co		
Subscriber Name		
Subscriber Birth Date		
Relationship to Patient		
Subscriber Employer		

I understand, have been offered a copy of, and agree to the terms in the Treatment, Payment, and Health Care Operations Policies of this office and hereby authorize payment for my treatment to be made directly to my provider in accordance to these policies. I further consent to receiving chiropractic treatment from the providers of Battle Ground Chiropractic. A copy of this authorization and consent shall serve as effective as the original. I certify that the above information is true and correct to the best of my knowledge.

Patient Signature:_____ **Date:** _____

Patient Name: _____ **Date:** _____

SYSTEMS REVIEW & HEALTH HISTORY

GENERAL SYSTEMS REVIEW: Do you **NOW** or have you in the **PAST** had any of the following conditions?

- Nerve-Muscle-Bone (NMS) disease ☐ Now ☐ Past _____
- Eye / Ear / Nose / Throat disease ☐ Now ☐ Past _____
- Heart or Lung or Blood/Blood Vessel (CR) conditions ☐ Now ☐ Past _____
- Digestive (GI) conditions ☐ Now ☐ Past _____
- Urinary (GU) conditions ☐ Now ☐ Past _____
- Hormonal-Diabetes-Thyroid (Endocrine) conditions ☐ Now ☐ Past _____
- Contagious blood or skin conditions ☐ Now ☐ Past _____
- Cancer ☐ Now ☐ Past _____
- Anxiety / Panic attacks / Depression ☐ Now ☐ Past _____
- **For Males**: Prostate conditions ☐ Now ☐ Past _____
- ***For Females***: OB-GYN Conditions ☐ Now ☐ Past _____

  Are you pregnant? ☐ No ☐ Yes Due Date: _____ OB/Midwife Name: _____
- Other health conditions: _____

Are you experiencing any unexplained: ☐ Fever ☐ Sickness ☐ Fatigue ☐ Weight Loss ☐ Weight Gain

FAMILY HEALTH HISTORY: Do you have family history of: ☐ Adopted/Unknown

Maternal: ☐ Arthritis ☐ Cancer ☐ Stroke/TIA ☐ Neurological Condition ☐ Diabetes ☐ Cardiac Condition

Paternal: ☐ Arthritis ☐ Cancer ☐ Stroke/TIA ☐ Neurological Condition ☐ Diabetes ☐ Cardiac Condition

MEDICATIONS:

Are you taking any prescription or over-the-counter medications? ☐ No ☐ Yes ☐ List attached

If yes, please identify: _____

_____

MAJOR PHYSICAL TRAUMAS: (please include year of occurrence and what was injured)

- Motor Vehicle Collisions _____ ☐ None
- Work Injuries _____ ☐ None
- Other Injuries _____ ☐ None

HOSPITALIZATIONS / SURGERIES: (*year and reason*) _____ ☐ None

_____

WORK ENVIRONMENT: ☐ Sedentary ☐ Physically Demanding ☐ Mixed _____% Sitting _____% Standing

- What is the average amount of hours you work each week? _____ hours/day _____ days/week

LIFESTYLE QUESTIONS:

- Do you smoke? ☐ No ☐ Quit (when)_____ ☐Yes (packs per day)_____
- Average hours of **sleep** per night:_____ Average hours of **exercise** per week:_____
- Hobbies/Recreational Activities:_____
- Rate your **daily diet:** ☐Excellent ☐Good ☐Fair ☐Poor **general health**: ☐Excellent ☐Good ☐Fair ☐ Poor

Patient Name:_____ **Date:**_____

Body Area/Chief Complaint 1_____

- Quality: ☐Numb ☐Tingly ☐Sharp ☐Dull ☐Achy ☐Tight/Stiff ☐Burning ☐_____
- Rate the severity of this complaint on a 0 (no pain) to 10 (worst pain) scale:
  Right **Now**_____/10 On **Average**_____/10 At **Worst**_____/10
- What percentage of your awake time do you experience this symptom intensity: _____%
- When/how did the symptom begin? _____ ☐suddenly ☐gradually
- Since onset, this symptom is ☐ Worsening ☐ Staying the Same ☐ Improving by _____%
- What makes the symptom worse? _____
- What makes the symptom better? _____
- Does the symptom refer/radiate to another part of your body? ☐ no ☐ yes_____
- Is the symptom worse at certain times of the ☐day or ☐night? Morning Afternoon Evening In Bed ☐No
- Previous Intervention: ☐ Chiropractic ☐ Massage ☐ Physical Therapy ☐ _____

Body Area/Chief Complaint 2_____

- Quality: ☐Numb ☐Tingly ☐Sharp ☐Dull ☐Achy ☐Tight/Stiff ☐Burning ☐_____
- Rate the severity of this complaint on a 0 (no pain) to 10 (worst pain) scale:
  Right **Now**_____/10 On **Average**_____/10 At **Worst**_____/10
- What percentage of your awake time do you experience this symptom intensity: _____%
- When/how did the symptom begin? _____ ☐suddenly ☐gradually
- Since onset, this symptom is ☐ Worsening ☐ Staying the Same ☐ Improving by _____%
- What makes the symptom worse? _____
- What makes the symptom better? _____
- Does the symptom refer/radiate to another part of your body? ☐ no ☐ yes_____
- Is the symptom worse at certain times of the ☐day or ☐night? Morning Afternoon Evening In Bed ☐No
- Previous Intervention: ☐ Chiropractic ☐ Massage ☐ Physical Therapy ☐ _____

Body Area/Chief Complaint 3_____

- Quality: ☐Numb ☐Tingly ☐Sharp ☐Dull ☐Achy ☐Tight/Stiff ☐Burning ☐_____
- Rate the severity of this complaint on a 0 (no pain) to 10 (worst pain) scale:
  Right **Now**_____/10 On **Average**_____/10 At **Worst**_____/10
- What percentage of your awake time do you experience this symptom intensity: _____%
- When/how did the symptom begin? _____ ☐suddenly ☐gradually
- Since onset, this symptom is ☐ Worsening ☐ Staying the Same ☐ Improving by _____%
- What makes the symptom worse? _____
- What makes the symptom better? _____
- Does the symptom refer/radiate to another part of your body? ☐ no ☐ yes_____
- Is the symptom worse at certain times of the ☐day or ☐night? Morning Afternoon Evening In Bed ☐No
- Previous Intervention: ☐ Chiropractic ☐ Massage ☐ Physical Therapy ☐ _____

Have any **X-ray, MRI and/or CT scan studies** been performed on this area? ☐ Yes ☐ No
When/Where/Findings_____

BATTLE GROUND CHIROPRACTIC

Treatment, Payment, and Health Care Operations Policies

HEALTH INSURANCE: Battle Ground Chiropractic's providers participate in most health plans. It is the responsibility of each patient to check the individual plan description for details about benefits and approved providers. Please have your card available at each visit, as this is a requirement of most insurance plans and our office staff may ask to view it upon check-in. This also ensures correct and timely billing of your insurance claim. If you have health insurance, Battle Ground Chiropractic will:

- Scan a copy of your insurance card(s) for our files
- Verify your benefits and eligibility
- Bill and process claims to your insurance company.

Please note, if your insurance company rejects your claim or does not pay in a timely manner, you may be required to make payment directly to us. Similarly, if your insurance company makes payment to you rather than the provider, you will be required to remit payment immediately, regardless of whether or not a statement has been generated by our clinic.

COPAYS/DEDUCTIBLES/COINSURANCE: ALL co-payments are due at the time of service, in accordance with the requirements of your health insurance plan. We accept cash, check, and most credit/debit cards. Estimated coinsurance and deductible amounts are due at the time of service unless other prior arrangements are made with clinic management. Battle Ground Chiropractic's staff will provide due diligence in estimating the patient's amount due as accurately as possible based on the insurance company's fee schedule on file. Because of the disclosures for claims reimbursement made by the insurance company, it is impossible for our staff to know the exact amount of patient responsibility before claims are processed.

PATIENT BILLING STATEMENTS: Statements are generated monthly, showing any remaining patient balance due after the insurance obligations have been met at that point. Payment is appreciated upon receipt, but is considered current if paid within 30 days of the statement date. If, for whatever reason, a patient is unable to make payment in full, reasonable arrangements may be made with the clinic management. If there is a credit balance on the patient's account after the insurance obligations have been met, Battle Ground Chiropractic will hold the credit on account for future use unless otherwise directed by the patient in writing.

NO INSURANCE: Patients without insurance can take advantage of Battle Ground Chiropractic's non-billing discount by paying for treatment on the day services are rendered. If payment in full is not received on the day of service, the account is in a billable state and is no longer eligible for a non-billing discount. In this case, a reasonable deposit on the full charges may be accepted at the day of service, with the balance due on the next patient billing statement unless other acceptable arrangements are made with management.

MOTOR VEHICLE COLLISION/THIRD PARTY/LIEN: The personal injury protection (PIP) carrier of the driver, regardless of fault, is the primary insurance coverage over any other insurance, and Battle Ground Chiropractic will bill as such. If the patient is a passenger and the driver does not have PIP coverage, then the patient's auto insurance PIP coverage becomes primary. If neither the driver nor the patient has PIP coverage, the case is considered a third party, or lien, claim. Third party/Lien claims are accepted on a case by case basis, whether represented or not by an attorney. Battle Ground Chiropractic reserves the right to not accept a third party or lien case unless adequate payment arrangements are agreed and made between the patient, the patients attorney (if applicable), and clinic management. All claim billing information must be given either at the time the appointment is made or no later than appointment date, or the first appointment may be rescheduled.

WORKER'S COMPENSATION: If you were injured on the job, Battle Ground Chiropractic will do the following:

1. provide you with the appropriate forms for you to complete in order to open a claim with either the State Fund (Department of Labor & Industries) or your employer's Self-Insured Fund carrier.
2. complete the provider's portion of this form and submit it to the proper carrier within the timelines set forth by industrial injury rules.
3. bill the appropriate carrier on your behalf.
4. provide you, and your employer, with any release from work or return to work notices, if necessary.

Please note, if your claim is denied, we will work with you to appeal if appropriate. You may be required to make payments on your account while the appeal is pending. If the appeal is denied, you will become responsible for the remaining amount due on the claim.

LATE/MISSED APPOINTMENTS: Battle Ground Chiropractic does its best to schedule patients in a timely manner according to availability of the schedule and the needs of the patient. We ask that patients return the same courtesy if circumstances arise that will cause tardiness or absence of a scheduled appointment by contacting the office at the earliest time possible so that we can adjust the schedule, reschedule the appointment, and/or fill the opening with another patient. If you do not notify the office and miss your scheduled appointment, a $25.00 missed appointment fee may be assessed to your account. Please note that most insurance plans do not pay for missed appointment fees.

UNPAID ACCOUNTS: In the event of failure to make payments at the time of service or when agreed upon, one or more of the following actions may be taken:

1. late fees added to the account—1% after 30 days, 2% after 60 days, 3% after 90 days
2. referral of the account to a collection agency
3. payment in full required before any further treatment can occur.

RETURNED CHECK FEE: There will be a $25.00 fee assessed for checks returned for non-sufficient funds (NSF).

I certify that I have read the above financial policies and agree to these policies. Initial:_____

Acknowledgments and Consents

NOTICE OF PRIVACY PRACTICES:
I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices._____

OTHERS INVOLVED IN MY HEALTH CARE, WITH WHOM I AUTHORIZE YOU TO USE AND/OR DISCLOSE MY PROTECTED HEALTH INFORMATION: Please indicate the person's name and relationship to the patient.

Name	Relationship

*I understand that I have the right to revoke this CONSENT provided that I do so **in writing**, except to the extent that Battle Ground Chiropractic has already used or disclosed the information in reliance on this CONSENT.*_____

INFORMED CONSENT TO CHIROPRACTIC MANIPULATIVE TREATMENT (CMT):

Chiropractic examinations and therapeutic procedures (including chiropractic manipulation, heat/cold application, trigger point, flexion/distraction, etc) are considered safe and effective methods of care. However, there are occasions when a procedure intended to help may have complications. These complications may include but are not limited to soreness, inflammation, soft tissue injury, dizziness, or temporary worsening of symptoms. More serious complications, such as strokes and disc herniations, are extremely rare and are usually already in process prior to treatment rather than caused solely by the treatment itself. This is why such a thorough evaluation, including review of past and current health, medications and family history is performed on all patients at the initial visit and at least annually thereafter.

Please inform your practitioner of any changes in symptoms, medications, diagnoses by other doctors, and if there is a chance of pregnancy at any time during your care. If you would like additional information on side effects/complication that could result from treatment, please discuss these with your practitioner prior to signing this consent. I understand the above statements concerning treatment side effects and risks, and I also understand that there is no guarantee for a specific cure or result. I further understand both my rights and responsibilities in this practitioner/patient relationship.

I have had the opportunity to read this form and ☐ have no questions ☐ have had my questions answered to my satisfaction. I hereby acknowledge and consent to the above

_____ _____
Patient Name or Legal Guardian (print) Date

_____
Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the above:

Date:_____ Attempt:_____ Staff Name:_____