



**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 INFORMATION

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		

Patient Name: _____ Date: _____ DOB: _____

PERSONAL, FAMILY & SOCIAL HISTORY

GENERAL HEALTH HISTORY: 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 Adopted/Unknown

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: _____ DOB: _____

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

Patient Name: _____ Date: _____ DOB: _____

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. Coinsurance and deductible amounts are due when the health plan processes the claim. Battle Ground Chiropractic's staff will provide due diligence to estimate the patient's amount due as accurately as possible based on the health plan'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. Patients will receive an Explanation of Benefits (EOB) directly from the health plan, as well as a patient statement from and payable to Battle Ground Chiropractic.

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 by the 30th of the month. 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.

NO INSURANCE/NON-COVERAGE: Patients without insurance or lack of benefit for a particular service can take advantage of Battle Ground Chiropractic's non-billing discount. We use Medicare's annual established limiting charge rate to determine the amount for each service. These rates are subject to change when Medicare updates these published rates.

MOTOR VEHICLE COLLISION/THIRD PARTY/LIEN: The personal injury protection (PIP) carrier of the car/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 has PIP coverage, the case is considered a third party, or lien, claim. Third party/Lien claims may be 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 and therefore will be assessed to the patient.

EXAMINATION/UPDATE ASSESSMENT APPOINTMENTS: A thorough examination, in addition to treatment, may be performed in the following circumstances:

1. first time ever being seen at Battle Ground Chiropractic (known as new patient exam)
2. when a patient has not been seen in the clinic for 6 months or more (if < 3 years = established patient; >3 years = new patient)
3. when a new symptom, condition, and/or injury occurs regardless of when the patient was last seen. This could be for a new slip/fall or other injury, work-related injury, auto accident, or just a new symptom area that has not been evaluated and treated in the past 6 months or more.

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). This policy is also posted at the front desk.

I certify that I have read 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. [REDACTED]

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.* [REDACTED]

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.

ASSIGNMENT OF HEALTH INSURANCE BENEFITS:

I authorize payment for my treatment to be made directly to my provider in accordance to the policies above and the governing documents of my health plan. I understand I have the right to revoke this authorization in writing at any time.

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)

DOB

Signature

Today's Date

Office Use Only

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

Date: _____ Attempt: _____ Staff Name: _____