Life Chiropractic
CENTER & Massage Therapy

Confidential Patient Information

Date: _____

Name: _____ Last Name: _____ Initial: _____

Dr. Ricky Sikka
www.thelifechiro.com
P: (253) 874-4141
F: (253) 874-3601

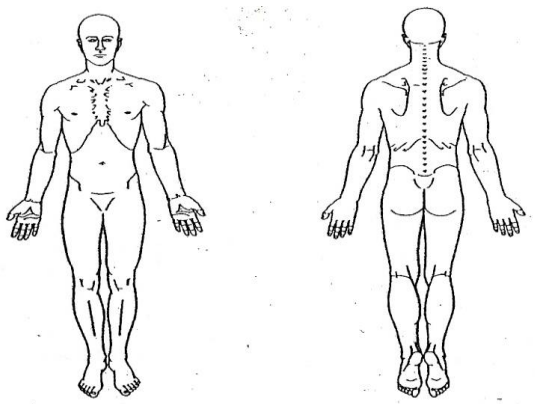
Major Complaint Information

What is your major complaint(s)? _____

_____

When did this (these) symptom(s) begin? _____

Using the symbols provided in the Pain Index, make the areas on the illustrations below where you are experiencing pain, followed by a number from 1-10 indicating the extent of the pain.
(1 being minor and 10 being severe)



Pain Index

B Burning **S** Sharp/Stabbing **N** Numbness

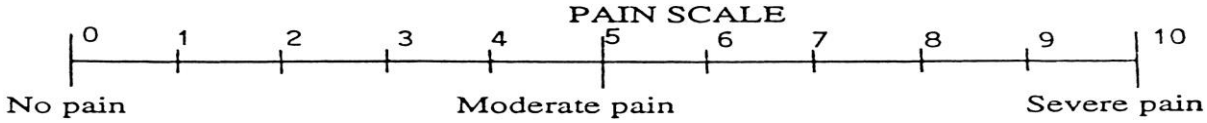
For example: if you are experiencing moderately severe burning pain in your neck, you should note "B8" on the neck of the illustration

If this is an injury, describe what happened:

_____

_____

_____



Have you experienced these symptoms before? ❍ Yes ❍ No When? _____

These symptoms developed from? ❍ Auto Accident ❍ Work-Related ❍ Other: _____

Have you reported this injury to your: Insurance Company ❍ Yes ❍ No Employer ❍ Yes ❍ No

What aggravates this condition? _____

What decreases the symptoms/pain? _____

Have you seen a doctor for this condition? ❍ Yes ❍ No Doctor's Name: _____

Date Consulted: _____ Diagnosis: _____

Have you missed work because of these injuries? ❍ Yes ❍ No From: _____ to _____

Does this condition interfere with your sleep? ❍ Yes ❍ No

If so, how many times do you wake up in pain per night? _____

In what position do you sleep? ❍ Back ❍ Stomach ❍ Side

Do you sleep with a pillow? ❍ Yes ❍ No How many? _____

Does heat affect the pain? ❍ Yes ❍ No If so, how? _____

Does cold affect the pain? ❍ Yes ❍ No If so, how? _____

Do you wear a heel lift? ❍ Yes ❍ No If so, which side? ❍ Right ❍ Left

Does it cause pain to cough, grunt, or sneeze? ❍ Yes ❍ No If so, where? _____

Check those activities below during which you experience difficulty or pain:

___ Lying on back	___ Getting in/out of car	___ Sleeping	___ Stooping	___ Standing for periods over 1 hour
___ Lying on side w/ knees bent	___ Gripping	___ Pushing	___ Sitting	___ Bending forward
	___ Climbing	___ Pulling	___ Coughing	___ Sneezing
___ Turning over in bed	___ Dressing self	___ Reaching	___ Walking	___ Bending Backward
___ Lying flat on stomach	___ Sexual activity	___ Kneeling	___ Other: _____	

Fill out the next three sections as they apply to you:

HEADACHES

Do you have a family history of headaches? ❍ Yes ❍ No Do you get headaches? ❍ Yes ❍ No Frequency? _____

Do you experience the following with your headaches: Pain or cracking in your jaw? ❍ Yes ❍ No

Abnormal blood pressure? ❍Yes ❍ No ❍ High ❍ Low Nausea, vomiting or visual disturbances? ❍ Yes ❍ No

When was your last eye exam by a doctor? ❍ 1-6 months ❍ 6-12 months ❍ 1-2 years ❍ over 2 years Results? _____

LOWER BACK PAIN

Do you ever experience a ripping or tearing sensation in your back? ❍ Yes ❍ No If so, where? _____

Does the pain radiate to the abdomen? ❍ Yes ❍ No

Do you ever have impaired bowel or urinary function? ❍ Yes ❍ No Explain: _____

NECK PAIN

If you have a neck injury, does it effect: (Check all that apply) ❍ Hearing ❍ Vision ❍ Balance ❍ Ringing in ears

Do you hear grating sounds? ❍ Yes ❍ No Do you feel pressure or pain behind your eyes? ❍ Yes ❍ No

Do you feel ripping or tearing? ❍ Yes ❍ No Where? _____

Do you have difficulty lifting or turning your head? ❍ Yes ❍ No If so, which direction? ❍ Right ❍ Left ❍ Up ❍ Down

Are you pregnant? ❍ Yes What is your due date? _____ ❍ No ❍ Not Sure First day of last menstrual cycle? _____

List all medications you are taking now, including over the counter medications. _____

_____

Are you allergic to any medication: ❍ Yes ❍ No ❍ Not Sure Please list: _____

_____

Have you ever had any surgeries or hospitalizations? ❍ Yes ❍ No Please List:

Type of Hospitalization/Surgery:	Date:	Type of Hospitalization/Surgery:	Date:
_____	_____	_____	_____
_____	_____	_____	_____

Have you been x-rayed in the last 12 months? ❍ Yes ❍ No Where? _____

Have you seen a chiropractor before? ❍ Yes ❍ No Please list:

Name of Chiropractor:	Date:	Name of Chiropractor:	Date:
_____	_____	_____	_____

Do you have a family physician? ❍ Yes ❍ No Name of physician: _____ Phone number: _____

Address: _____

City/State/Zip: _____

Additional Complaints

Please check all additional complaints that you have at this time:

❍ Digestion Trouble	❍ Neck Stiffness	❍ Neck Pain	❍ Cold Feet	❍ Arthritis	❍ Jaw Pain	❍ HIV (Aids)
❍ Loss of Concentration	❍ Neck Motion Restricted	❍ Irritable	❍ Anxiety	❍ Depression	❍ Insomnia	❍ Diarrhea
❍ Loss of Consciousness	❍ Upper Back Pain/Stiffness	❍ Hypertension	❍ Diabetes	❍ Hepatitis	❍ Convulsions	❍ Other: (List)
❍ Eyes Sensitive to Light	❍ Mid Back Pain/Stiffness	❍ Memory Loss	❍ Flushed Face	❍ Dizziness	❍ Fainting	_____
❍ Heavy Feeling in Head	❍ Low Back Pain/Stiffness	❍ Palpitation	❍ Chest Pain	❍ Nausea	❍ Vomiting	_____
❍ Shortness of Breathe	❍ Right/Left Shoulder Pain	❍ Anemia	❍ Nervousness	❍ Cold Hands	❍ Constipation	❍Allergies(List)
❍ Excessive Perspiration	❍ Right/Left Arm Pain	❍ Sinus Trouble	❍ Vision Problems	❍ Loss of Smell	❍ Cancer	_____
❍ Loss of Balance	❍ Right/Left Leg Pain	❍ Headaches	❍ Heart Disease	❍ Loss of Taste	❍ Fatigue	_____
❍ Pins/Needles Arm/Leg	❍ PLEASE SPECIFY LOCATIONS:		❍ Cuts _____		❍ Bleeding _____	
❍ Pain behind Eyes	❍ Bruising _____	❍ Swelling _____		❍ Numbness _____		

Do you have, or have you ever had, any diseases or medical problems not listed above? ❍ Yes ❍ No If so, please list: _____

_____

Any additional information you would like the doctor to know before beginning care at Life Chiropractic Center? _____

_____

Emergency Contact

Name: _____ Relation: _____

Contact Number: _____Address:_____

Auto Insurance Information **Give Insurance Information to Receptionist**

Auto Insurance Company: _____ Claim Number: _____

3rd Party Insurance Company: _____ Claim Number: _____

Personal Information

Address: _____ City: _____ State: _____Zip: _____

❍ Home #: _____ ❍ Cell #: _____ Cell Carrier (Appt. Reminders): _____

❍ Email: _____ (Check best way to contact you)

Sex: ❍ M ❍ F Soc. Security #: _____ Age: _____ Date of Birth: _____

Marital Status: ❍ Married ❍ Single ❍ Divorced ❍Widowed ❍ Separated Spouse Name: _____ # of children: _____

Occupation/Job Title: _____ Employer: _____

Employers address: _____

How were you referred to Life Chiropractic Center? _____

Do you have an attorney? ❍ Yes ❍ No Name: _____

Auto Accident Information
(Please allow the receptionist to copy the Police Report)

Accident Date: _____ Accident Time: ___ _____ At Fault Person's Name: _____

Accident Location: _____ City: _____State: _____

List what symptoms you suffer with as a result of the accident?

1. _____

❍ Occasional ❍ Comes & Goes ❍ Frequently ❍ Constant Please rate intensity: No Problem 0 1 2 3 4 5 6 7 8 9 10 Severe

2. _____

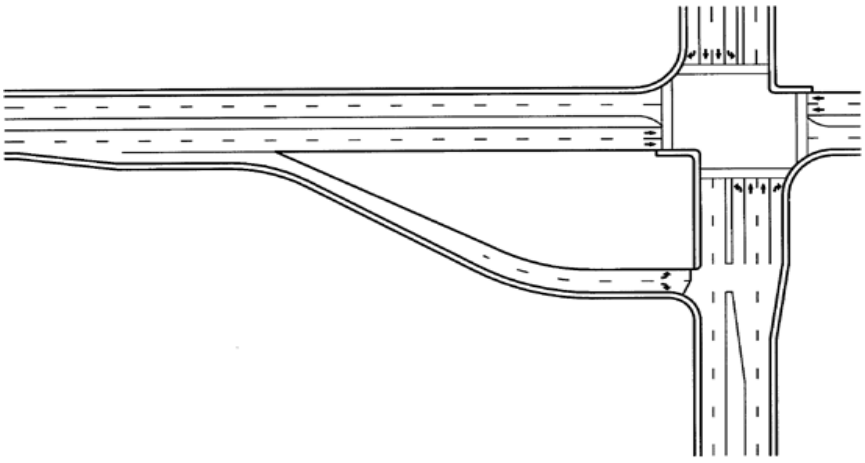
❍ Occasional ❍ Comes & Goes ❍ Frequently ❍ Constant Please rate intensity: No Problem 0 1 2 3 4 5 6 7 8 9 10 Severe

3. _____

❍ Occasional ❍ Comes & Goes ❍ Frequently ❍ Constant Please rate intensity: No Problem 0 1 2 3 4 5 6 7 8 9 10 Severe

Were you the: ❍ Driver ❍ Passenger ❍ Front ❍ Back # of people in the car: _____
Did you wear a Seatbelt? ❍ Yes ❍ No
Road Conditions: ❍ Wet ❍ Dry ❍ Slippery
Estimated damage to patient's car: _____
Did your vehicle spin or rollover? ❍ Yes ❍ No
Did your vehicle get hit into another: ❍ Vehicle ❍ Object ❍ None
Were you aware you were about to be in an accident? ❍ Yes ❍ No
Did you have your ❍ feet or ❍ foot braced on: ❍ floor board ❍ brake ❍ neither
Were your hands on the wheel? ❍ Yes ❍ No
Did you brace yourself? ❍ Yes ❍ No ❍ Don't remember
Was your head turned at the time of impact? ❍ Yes ❍ No ❍ Right ❍ Left ❍ Don't remember
Were you leaning forward at time of impact? ❍ Yes ❍ No ❍ Don't remember
Was your body turned at time of impact? ❍ Yes ❍ No ❍ Right ❍ Left ❍ Don't remember
Did you hit your head or any other part of your body on anything? ❍ Yes ❍ No ❍ Don't remember
Did you feel: ❍ Dazed ❍ Disoriented ❍ Have patchy loss of time Did you see stars/checkerboard vision? ❍ Yes ❍ No
Were you rendered unconscious? ❍ Yes ❍ No ❍ Don't remember Did the airbags in your vehicle engage? ❍ Yes ❍ No
What is the first thing you remember after the impact? _____
If considerable time has lapsed since the trauma, why did you wait so long to seek treatment/evaluation? _____
In your lifetime have you had any other accidents/traumas/injuries? ❍ Yes ❍ No When were they? _____

Please note the events that occurred:



_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Life Chiropractic
CENTER & Massage Therapy

Agreement to Payment in Full

Patient Name: _____

Date of Injury: _____

To Attorney: _____

The undersigned patient (hereafter "patient") of hereafter "Life Chiropractic & Massage" authorizes the clinic to furnish my attorney named above (hereafter "attorney") with all documents relating to my care for the injury of above date (hereafter injury") that are in possession of clinic, regardless of where or by whom such documents originated.

I authorize and direct my attorney to pay to the clinic all such sums as may be due and owing the clinic for treatment relating to my injury. I specifically direct my attorney to withhold such monies out of any award or settlement that would be otherwise net payable to me when my claim for injuries resolves.

I acknowledge full responsibility for payment of all my bills owing to the clinic. I also specifically agree that the clinic may withhold collection on my account in exchange for my promise to have my attorney pay my bills out of any resolution of my injury claim. I agree not to rescind the terms of this agreement, and I direct my attorney to not be bound by any attempt at rescission on my part. I hereby direct that my attorney pay my bill to Life Chiropractic Center out of monies that would be otherwise net payable to me at the time of resolution of my claim.

This direction to my attorney in no way releases me from the obligation to pay the clinic on my bill and I understand that this obligation to pay is not contingent on my recovering on my claim, I agree that if the clinic is not paid on my account, the clinic may take whatever collection efforts it chooses against me, and I shall be responsible for all costs of collection including reasonable attorneys fees and costs incurred by the clinic or its collecting monies owed by me.

I have been advised by the clinic that if my attorney does not wish to sign this document, that the clinic may declare my entire bill due and owing at any time clinic chooses. If the patient is a minor or incompetent person, I represent that I am the guardian or representative of that person and have lawful representation.

Dated: _____ Patient's Name (printed): _____

Patient's Signature: _____

Acknowledgement of Attorney

The undersigned, being attorney for above named patient in the claim for injuries of above stated date, agrees to the above terms and agrees to withhold from any settlement, award, judgment, or verdict any monies that would be otherwise net payable to patient in resolution of patient's claim.

Date: _____ Attorney's Name (printed): _____

Attorney's Signature: _____

Informed Consent

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fees or court costs required to collect my bill.

I hereby authorize physicians and staff at Life Chiropractic (aka R&R Chiropractic LLC) to treat my condition as deemed appropriate. It is understood and agreed the amount paid to the doctor for X-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen any time. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Life Chiropractic responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as many other types of health care, is associated with potential risks in the delivery of treatment. Therefore it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific Risk Possibilities Associated with Chiropractic Care.

Soreness- Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort.

Soft Tissue Injury- Occasionally chiropractic treatment may aggravate a disc injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

Rib Injury- Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for case considered at risk. Treatment is performed carefully to minimize such risk.

Stroke- Stroke is the most serious complication of chiropractic treatment. The most recent studies (*Journal of the CAA*, Vol. 37 No. 2, June 1993) estimate that the incidence of this type of stroke is 1 in every 3 million upper cervical adjustments.

Other Problems- There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

If you have any questions concerning this form or the above statements, please ask your doctor.

Having carefully read the above, I hereby give my consent to have chiropractic treatment administered to myself or the person named below

.

_____ _____

Patient Signature Date

_____ _____

Parent/Legal Guardian Signature Date

_____ _____

Interpreter Name Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW CHIROPRACTIC/MEDICAL INFORMATION ABOUT YOU MAY BE DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Life Chiropractic Center we may use or disclose personal and health related information about you in the following ways:

- Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of services provided to you.
- Your name, address, phone number, e-mail address, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.
- If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

You have a right to request restrictions on our use of your protected health information for treatment, payment, and operations purposes. Such requests are not automatic and require the agreement of this office. We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

You have a right to receive an accounting of any such disclosures made by this office. Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subject to redisclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules. We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a specific form please advise us in writing as to your preferences.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information, and are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files. If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities, or if you would like further information about our privacy policies and practices please contact:

Dr. Ricky Sikka- Privacy Officer at 34507 Pacific Hwy S, Ste 4, Federal Way, WA 98003 (253) 874-4141

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.

This office utilizes an "open adjusting" environment for ongoing patient care. "Open adjusting" involves several patients being seen in the same general adjusting area at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, providing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment other arrangements will be made for you.

This notice is effective as of January 2, 2015. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____ _____ _____

Name (Please Print) Signature Date

_____ _____

Parent/Legal Guardian Signature Date

Life Chiropractic
CENTER & Massage Therapy

Life Chiropractic and Massage
No-Show/Cancellation Policy

I, _____, consent to and understand the following policy:

It is understood and agreed that Life Chiropractic and Massage requires that all patients provide a 24-hour cancellation notice. Failure to cancel or show for a scheduled appointment will result in a $80.00 charge for each occurrence.

I am aware that this charge cannot be billed to my Insurance and that I will be responsible for this fee. Below, is the payment method that I, _____, consent to be automatically charged if there is not a 24-hour cancellation notice.

I CERTIFY THAT I HAVE READ THIS FORM AND THAT I UNDERSTAND ITS CONTENTS. MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION AND I ACKNOWLEDGE RECEIPT OF A COPY OF THIS FORM (if requested).

Patient Signature (if not a minor): _____

Date: _____ Time: _____

The patient is unable to consent because: ☐ They are a minor

☐ Other: _____

Signature of Parent or Guardian: _____

Relationship to Patient: _____

Date: _____ Time: _____ Witness: _____

CREDIT CARD INFORMATION

Please Circle One: VISA MASTERCARD DISCOVER AMEX

_____

Expiration Date: _____ 3-Digit Code: _____

Life Chiropractic
CENTER & Massage Therapy

Patient:

DOB:

ASSIGNMENT OF BENEFITS AGREEMENT

Our office will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand, though, that the contract regarding your benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.
- We require you to sign this form and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.

R&R Chiropractic LLC
DBA: Life Chiropractic and Massage
34507 Pacific Highway South, Suite 4
Federal Way, WA 98003
Tax ID: 47-1179110

- We require you to pay the co-payment, which is the amount not covered by your insurance company, at the time we provide service to you.
- Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our office within 60 days, we will ask you to pay the balance due at that time. You will be responsible for seeking reimbursement from your insurance company at that time.
- Our office does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.
- Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY MEDICAL BENEFITS DIRECTLY TO THE DOCTOR.

_____ _____

Signature of Patient/Responsible Party Date

I AUTHORIZE YOU TO DEBIT MY CREDIT CARD IF YOU HAVE NOT RECEIVED PAYMENT FROM MY INSURANCE COMPANY WITHIN 60 DAYS OF RECEIVING TREATMENT.

_____ _____ _____ _____

Print Name Credit Card # (Optional) Expiration Date V-Code