Basin Family Chiropractic

2200 S. Maiers Rd, Suite B • Moses Lake, WA 98837 • Phone: (509) 764-8626 • Fax: (509) 764-8628

www.basinfamilychiropractic.com

NAME:_____ GENDER: ☐MALE ☐ FEMALE
LAST NAME FIRST NAME, LEGAL MIDDLE INITIAL

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

E-MAIL:_____ DOB:____/____/____ SS#:____/____/____

HIPPA Phone Authorization: I authorize Basin Family Chiropractic to leave messages on my voicemail in regards to information regarding appointments, treatment related issues, and billing issues
At the following number(s) checked below (you must specify at least one phone number) :

☐**E-MAIL** Listed Above☐[H](_____) _____-_____ ☐[W](_____) _____-_____ ☐[C](_____)_ _____-_____

HIPPA phone authorization <u>other</u> than patient: This authorization will remain in effect until you choose to revoke it. I authorize Basin Family Chiropractic to leave a message for, or speak to the specified individual(s) listed below in regards to information regarding appointments, treatment related issues and billing issues: (this person must provide us with your date of birth).
☐ At my home number with (name)_____
☐ At another number (_____-_____-_____) with (name)_____
You have the right to withdraw this authorization at any time. Such revocation <u>must be in writing.</u>

EMPLOYER:_____ CITY:_____ STATE:_____
MARITAL STATUS: Single Married Divorced Widowed Separated
PRIMARY INSURED'S NAME:_____ DOB____/____/____
EMERGENCY CONTACT(not living with you):_____PHONE (_____)_____-_____

Who may we thank for referring you? _____

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR PURPOSE OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS & FINANCIAL AGREEMENT : HIPPA I hereby authorize *Basin Family Chiropractic* to use and disclose the health & medical information, via fax, mail or electronically for the purpose of treatment, payment, and health care operations. I also authorize the physician to release any information to referring/consulting physicians or other health care providers, as your physician deems appropriate to facilitate my/our care. I hereby assign payment to be directly issued to *Basin Family Chiropractic* for any benefits available under my coverage and/or settlement for treatment and/or expenses incurred at this office. I agree that this Assignment of Benefits and Authorization to release information irrevocable and that I am waiving the statute of limitations for payment. I have been informed of the $20 fee on checks returned. In the event the account goes to collection I agree to pay interest, collection fees, and will not withhold/delay payment, and that I am responsible for my/my child's bill. **I understand that I am responsible for knowing my medical benefits/limits/ exclusions.**

WAIVER FOR PAYMENT OF NON-COVERED OR EXCLUDED MEDICAL SERVICES: non-covered or excluded medical services are identified in the information your health care plan provided to you. Additional examples of non-covered services may include: "maintenance or palliative care" chiropractic treatment(s), manual massage, manual traction, trigger point therapy, exercise instructions, re-exams, medical equipment, treatment without a referral and/or authorization, and missed massage appointments. Medicare follows guidelines under Section 1862 (a) (1) of the Social Security Act to determine which medical services are reasonable and necessary. Medicare will only cover spinal manipulations. Labor & Industries does not cover supplies. <u>I understand that there may be certain procedures/supplies/charges that are not covered by my insurance/3rd party settlement, and agree that I am financially responsible for those charges.</u>

✖CONSENT TO TREATMENT OF A MINOR: As parents or legal guardian, I have the authority to authorize, and do hereby grant the Chiropractor(s) at Basin Family Chiropractic, to administer chiropractic care as he/she deems necessary to my son/daughter/ward. I also agree to massage therapy by the LMP(s):

☞**Name of Minor**_____
☞**Print Adult Name**_____

My signature below acknowledges that I have reviewed, understand and agree to the HIPPA phone authorization, authorization to release information/assignment of benefits, financial policy, waiver for payment of non-covered/excluded services & consent to the treatment of a minor. By refusing to sign I understand that I, or my child will not be able to receive care in this office.

☞**PATIENT** (or Legal Guardian signature):_____ **DATE:** ____/____/____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care. We may conduct some diagnostic or examination procedures if indicated. And examinations or tests conducted will be done carefully. Treatment provided in this office include, but not limited to: spinal manipulation, traction, myofascial release, massage therapy and therapeutic exercise. Potential benefits of treatment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, improving neurological function and overall wellbeing. It is important that you understand, as with all health care approaches results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care including, but not limited to: muscle spasms, aggravation and/or scarring from hot or cold therapies, fractures, disc injuries, strokes, dislocations, strains and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. If you are experiencing neck pain with any difficulty speaking, double vision, slurred speech, difficulty moving or walking please tell the Doctor that you are experiencing these symptoms, because you may be experiencing an arterial dissection (which is an extremely rare event).

It is also important that you understand there are treatment options available for your condition other than our office procedures. Likely, you have tried many of these approaches already. There options may include, but are not limited to: self-administered care, over the counter pain relievers, rest, medical care with prescription medication, physical therapy, bracing, injections and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I understand that it is not possible to consider every complication to care. I have also had an opportunity to ask questions about its content and by signing below, I agree with the current or future recommendations to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all the providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office. I have read, or have had read to me, the above consent.

Patient Name:_____ Signature:_____ Date:_____

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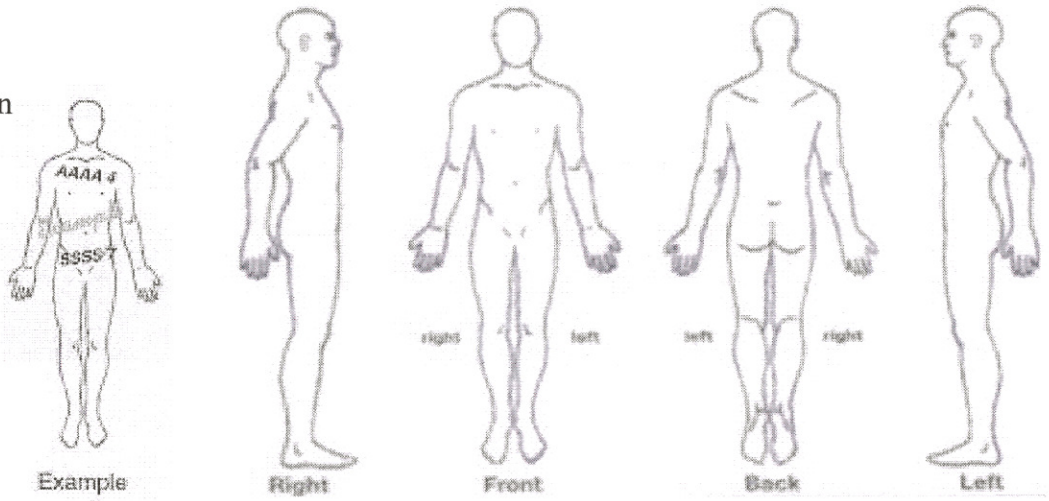
INITIAL COMPLAINT

Patient Name: _____ **Birthday:**_____ **Todays Date:** ___/___/_____
Primary Care Physician & Clinic: _____ **Phone:** (____) ____-_____
Chiropractor/Therapists previously treating you for this condition: _____
Date of initial onset for this condition: ___/___/_____ If reoccurrence, date of current aggravation: _____/_____/_____
When did your problem begin? ☐ **Immediately after a specific incident** ☐ **Multiple incidents** ☐ **Gradually**
Please Describe any incidents:

Pain Diagram:
Use symbols below to mark all areas using pain scale from 1 (discomfort) to 10 (extreme pain).

Description:
AAA = Aching
NNN = Numbness
SSSS = Stabbing
BBB = Burning
PPPP = Pins/Needles
TTT = Throbbing



Frequency (overall): ☐Constant (76-100%) ☐Frequent (51-75%) ☐Occasional (26-50%) ☐Intermittent (25-49%)

Your general stress level: ☐ No Stress ☐Minimal Stress ☐Moderate Stress ☐Greatly Stressed
Physical Activity at work: ☐Sitting 75% of day ☐Light Manual Labor ☐Manual Labor ☐Heavy Labor
General Physical Activity: ☐No Regular Exercise ☐Light Exercise Program ☐Strenuous exercise program
Are you currently pregnant? Yes/No
Vitamins/Supplement Consumption: _____
Do you use alcohol? Yes / No If yes how much?_____
Do you Smoke? Yes / No If yes how often?_____

Personal Health History

PAST	PRESENT		PAST	PRESENT	
☐	☐	Neck Pain	☐	☐	Vertigo (Dizziness)
☐	☐	Shoulder Pain	☐	☐	Diabetes
☐	☐	Lower Back Pain	☐	☐	Cancer
☐	☐	Upper Back Pain	☐	☐	Stroke
☐	☐	Numbness in Arms or Legs	☐	☐	Heart Attack
☐	☐	Osteoarthritis	☐	☐	High Blood Pressure
☐	☐	Rheumatoid Arthritis	☐	☐	Loss of Bladder Control
☐	☐	Osteoporosis	☐	☐	Chest Pain
☐	☐	Headaches	☐	☐	Loss of Consciousness
☐	☐	Fractures_____	☐	☐	Depression or Anxiety
			☐	☐	Concussion

Surgeries_____
_____

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MVA ELIGIBILITY CHECK-LIST AND FINANCIAL POLICY

Patient Name: _____ **Today's Date:** _____

Date of Injury: _____ Time of Injury: _____

Name of YOUR Car Insurance Company: _____ Claim # _____

Have you reported your accident to your insurance company? ☐ Yes ☐ No Policy # _____

Name of who is "INSURED" _____ Relationship to you: _____

Name of YOUR claims adjuster: _____ Phone # _____

Do YOU have Personal Injury Protection (PIP) benefits? ☐ Yes ☐ No "PIP" limit amount: $_____

Location/Address of Accident: _____ City: _____

Did the police come to the accident? ☐Yes ☐No Did you fill out a police report of the accident? ☐Yes ☐No

Name of Attorney: _____ Phone: _____

Address: _____ City: _____ Zip: _____

Name of the Other Driver involved in the accident: _____ Phone: _____

Their Address: _____ City: _____ Zip: _____

Other Drivers Car Insurance Company: _____ Claim # _____

Name of the other's insured Claims Adjuster: _____ Phone: _____

FINANCIAL POLICY

As a patient of this office, you are directly responsible for all charges incurred. If your car accident claim is denied you are fully responsible for prompt payment. If your PIP cannot be verified as open and payable, you will be required to pay cash for your visit(s). if your PIP is maxed, we will bill your health insurance. If you refuse to sign below, you acknowledge that you will be required to pay for all charges incurred at the time of your visit(s).

HIPPA Notification & Authorization to Release information: I hereby authorize the office of Basin Family Chiropractic to release necessary information to file a medical lien to secure payment for care received from Basin Family Chiropractic should the need arise. The information on the medical is made public record. It identifies the patient, their address, 3rd party, insurance parties involved, date of accident, location of accident and gives a general medical description of the conditions being treated:
"Soft tissue injuries to the spine, paravertebral structures and extremities."

_____ _____ _____

Print Patient/Guardian Name Signature of Patient/Guardian Date

Office Use Only

VERIFICATION OF MOTOR VEHICLE ACCIDENT INSURANCE

Spoke with: _____ Phone: _____ Date: _____

Claim Adjustors Name: _____ Phone: _____ Ext: _____

Verify Date of Accident: _____ Verify Claim # _____

*Is there a PIP Policy? ☐ Yes ☐ No *Has the Patient turned in the PIP application? ☐ Yes ☐ No

*Is the PIP open and Payable? ☐ Yes ☐ No *Are they close to being exhausted? ☐ Yes ☐ No

Has the patient been required to have an I.M.E.? ☐ Yes ☐ No If so, with whom? _____

Mail Claims To: _____

_____

_____

Third Party Verification

Insurance: _____

Claim # _____

Phone # _____

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MECHANISM OF INJURY QUESTIONAIRE

Patient Name: _____ **Today's Date:** _____

Date of Accident: _____ Time of Accident: _____

Police Investigation by: ☐ Washington State Patrol ☐ City Police ☐ County Police ☐ Other: _____

Road Conditions: ☐ Wet ☐ Dry ☐ Icy ☐ Other- Describe: _____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger → ☐ Left ☐ Right ☐ Center

Were you aware of the approaching collision prior to the impact? ☐ Yes ☐ No

Were you rendered unconscious (blackout): ☐ Yes ☐ No If yes, how long? _____

During impact, were you facing: ☐ Right ☐ Left ☐ Forward

Were you struck from: ☐ Behind ☐ Front ☐ Left Side ☐ Right Side

Were you wearing a seat belt? ☐ Yes ☐ No If Yes, was it: ☐ Lap-Belt Only ☐ Shoulder & Lap Belt

Is your car equipped with an airbag? ☐ Yes ☐ No *If yes, did the airbag activate? ☐ Yes ☐ No

Was your car stopped at the time of impact? ☐ Yes ☐ No

*If yes, was the driver's foot on the brake? ☐ Yes ☐ No

* If yes, was the brake being pressed down? ☐ Slightly ☐ Moderately ☐ Strongly

If your vehicle was moving, was it: ☐ Gaining Speed ☐ Slowing Down ☐ Steady Speed (_____ MPH)

Please describe to the best of your knowledge, what happened: _____

_____

_____

Indicate Symptoms That Are A Result Of This Accident:

☐Dizziness	☐Difficulty sleeping	☐Jaw problems
☐Memory loss	☐Irritability	☐Arms/Shoulder pain
☐Headache(s)	☐Fatigue	☐Numb Hand/Finger
☐Blurred vision	☐Tension	☐Chest pain
☐Buzzing in ear	☐Neck pain	☐Shortness of breath
☐Ears ringing	☐Neck stiff	☐Stomach upset
☐Leg pain	☐Back stiffness	☐Nausea
☐Back Pain	☐Low back pain	☐Numb Feet/Toes
☐Other_____		

Indicate Degree Of Comfort While Performing The Following Activities:

	Uncomfortable	Painful
Lying down	☐	☐
Sit/Stand	☐	☐
Walk/Run	☐	☐
Sports	☐	☐
Working	☐	☐
Lifting	☐	☐
Bending	☐	☐
Pulling	☐	☐

What type of car were you in? Year _____ Make _____ Model _____

Did <u>any</u> part of your body strike anything in the vehicle? ☐ Yes ☐ No If yes, please explain: _____

During Impact, were you facing: ☐ Right ☐ Left ☐ Forward

Was your vehicle moved/pushed upon impact? ☐ Yes ☐ No

If so, how much? ☐ Less than one car length ☐ One car length ☐ More than one car length

Did your car hit anything else after it was hit? ☐ Yes ☐ No If yes, what else? _____

How long after the accident did your pain begin? _____

Patient Signature: _____ **Date:** _____

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Name of Patient: _____

Patient Date of Birth: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of Provider's Notice of Privacy Practices with the effective date of _____.

_____ _____

Signature of Patient/Patient Representative Date

_____

Relationship to Patient

Office Use Only

Documentation of Good Faith Efforts To obtain patient's acknowledgement that they received provider's Notice of Privacy Practices

(For use when acknowledgement cannot be obtained from the patient.)

The patient presented to the office on _____/_____/_____ and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the notice. However, such acknowledgement was not obtained because:

☐ Patient Refused to Sign

☐ Patient was unable to sign or initial because:

_____

☐ The patient had a medical emergency, and an attempt to obtain the acknowledgement will be made at the next available opportunity.

☐ Other reason (describe below):

_____

Signature of Employee Completing Form: _____

Date Signed: _____/_____/_____