Finnigan CHIROPRACTIC

New Patient Paperwork

Demographic Information

Patient Name (As Appears on Insurance Card)

Preferred Name DOB SSN

Parent/Guardian Name (if applicable)

Sex at Birth: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Separated/Divorced ☐ Widowed

Address

City State Zip Email

Cell Phone Home Phone

Spouse/Partner Name Phone Number

ER Contact Relationship Phone Number

Employment Status: ☐ Part Time ☐ Full Time ☐ Self Employed ☐ Homemaker ☐ Unemployed ☐ Retired

Occupation Employer

Primary Care Physician

Who may we thank for referring you?

Insurance Information

☐ No Insurance ☐ Health Insurance ☐ Medicare/MedAdvantage ☐ VA

We are **not** currently contracted with Aetna HMO, United Healthcare, Cigna, First Choice, Tricare HNSF, and Washington Apple Health Plans and **do not** bill them. Some of these plans have out of network benefits and you may receive reimbursement by submitting a member claim. The process for this is different for each insurance and we will gladly provide billing information upon request.

Primary Plan Name ID#

Secondary Plan Name ID#

We accept workers compensation, car accident and personal injury protection claims. **Please note, if you were not at fault and coverage is being provided by a 3rd party auto insurance, we require a letter of representation from your attorney to hold billing until your claim is resolved.**

☐ Workers Compensation Auto Accident ☐ At Fault ☐ Not At Fault Date of Accident:

Do you have Personal Injury Protection (PIP) through your auto insurance? ☐ Yes ☐ No ☐ Not Sure

Insurance Name Claim #

Claim Adjustor Phone #

Attorney Name Phone #

No Show Policy

We value your time and are committed to providing personalized, high-quality care. To best serve all our patients, we have implemented the following No-Show Policy:

A **"no-show"** is defined as a missed appointment without prior notice to cancel or reschedule. This includes patients who arrive more than **15 minutes late** and cannot be accommodated due to scheduling constraints.

- **Chiropractic Appointments**: A **$30 fee** may be charged to your account if an appointment is missed without any communication.
- **Body Sculpting Appointments**: A **$50 fee** may be charged to your account for missed appointments without 24 hours' advanced notice.
- **Massage Appointments**: A **$100 fee** may be charged to your account for missed appointments without 48 hours' advanced notice.
- **Repeated No Shows**: In addition to incurring the above listed fees, you may be required to pre-pay or leave a deposit for future appointments.

Why This Policy Is Important
Missed appointments disrupt continuity of care and limit appointment availability for other patients in need. Repeated no-shows may result in delayed treatment outcomes and could impact your overall health progress.

How to Cancel or Reschedule
For your convenience, we have several methods of communication including:

- Phone (360) 459-7800
- Text (360) 523-1261
- Email frontdesk@finniganclinic.com.

If it's outside of regular hours, please leave a voicemail or send an email. We understand that things happen and will take extenuating circumstances into consideration.

Financial Agreement

The above information is true and accurate to the best of my knowledge. I understand and agree that medical and accident insurance coverage is a contract between me and my insurance company and/or employer. It is my responsibility to know my insurance benefits and whether a referral or prior authorization is required. I understand that I am financially responsible for all services provided by Finnigan Chiropractic, and I agree to promptly pay all invoices from this office. I also understand and agree to notify the office immediately of any insurance or demographic changes.

I understand that these policies may change without notice and that a copy of this agreement is available upon request.

Patient Name _____

Parent/Guardian Name _____

Signature _____ Date _____

Reason for Visit

1. **Primary Complaint**

How long have you suffered from this problem?

How severe is this condition at its worst? 1 2 3 4 5 6 7 8 9 10

2. **Second Complaint**

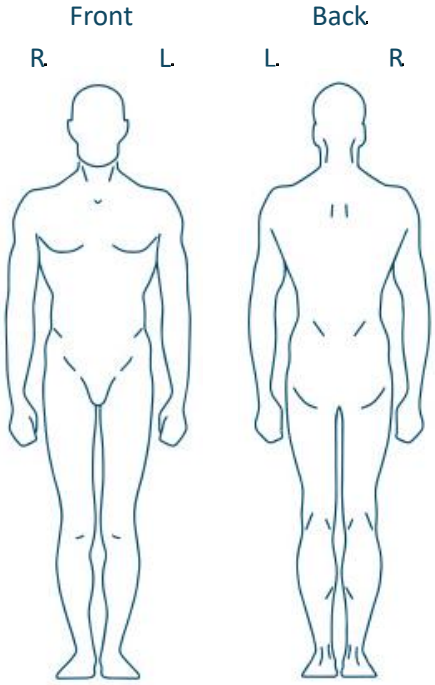
How long have you suffered from this problem?

How severe is this condition at its worst? 1 2 3 4 5 6 7 8 9 10

3. **Third Complaint**

How long have you suffered from this problem?

How severe is this condition at its worst? 1 2 3 4 5 6 7 8 9 10



4. **What have you done to remedy this in the past and was it helpful?**

Modality	Very	Mildly	Not	Modality	Very	Mildly	Not
☐ Chiropractic Care	☐	☐	☐	☐ Dietary Changes	☐	☐	☐
☐ Physical Therapy	☐	☐	☐	☐ Medication	☐	☐	☐
☐ Massage Therapy	☐	☐	☐	☐ Surgery	☐	☐	☐
☐ Acupuncture	☐	☐	☐	☐ Injections	☐	☐	☐
☐ Exercise/Fitness	☐	☐	☐	☐ Nothing	☐	☐	☐
☐ Stretching/Mobility	☐	☐	☐	☐ _____	☐	☐	☐

5. **How are the problems impacting your daily life?**

Area of Life	Not	Mild	Mod	Severe	Describe
Daily Activities	☐	☐	☐	☐	
Work	☐	☐	☐	☐	
Family / Relationships	☐	☐	☐	☐	
Hobbies / Activities	☐	☐	☐	☐	
Mood / Stress Levels	☐	☐	☐	☐	
Sleep	☐	☐	☐	☐	
Motivation	☐	☐	☐	☐	
Future Health & Abilities	☐	☐	☐	☐	
Overall Quality of Life	☐	☐	☐	☐	

6. **When these problems are at their worst, describe how they make you feel?**

Future Health Outlook

7. **If these problems continue, or get worse, where do you picture yourself in 1 year? 5 years? (Be specific)**

8. **Are you concerned they are getting worse?**

Not Important ----------> Extremely Important

9. **How important is it for you to resolve your health concerns?** 1 2 3 4 5 6 7 8 9 10

10. **How prepared are you to prioritize the changes necessary to achieve your health goals?**

	Not Committed ----------> Extremely Committed									
Change Daily Habits/Routines	1	2	3	4	5	6	7	8	9	10
Alter Diet/Nutrition	1	2	3	4	5	6	7	8	9	10
Follow Home Care Recommendations	1	2	3	4	5	6	7	8	9	10
Keeping Scheduled Appointments	1	2	3	4	5	6	7	8	9	10
Financial Commitment	1	2	3	4	5	6	7	8	9	10

11. **What challenges or barriers may make it difficult for you to follow through with care recommendations?**

☐ Financial Concerns ☐ Time Constraints ☐ Work Schedule ☐ Unsure About Treatment

☐ Other: _____

12. **How would life be different if you didn't have to suffer from these problems?** _____

13. **What best describes your goals for care?**

☐ To get information on alternative treatment options.

☐ To temporarily reduce or manage acute symptoms (think Band-Aid).

☐ To find a solution that addresses the underlying cause of my conditions.

14. **Why do you think our office can help you?** _____

☐ I am not sure it can help me.

Notice of Privacy Practices

Finnigan Chiropractic is committed to protecting the privacy and confidentiality of your protected health information as required by the Health Insurance Portability and Accountability Act (HIPAA).

Our Notice of Privacy Practices describes:

- How medical information about you may be used and disclosed
- Your rights regarding your health information
- How you can obtain access to this information

A copy of our current Notice of Privacy Practices is available upon request.

I acknowledge that I have been offered a copy of Finnigan Chiropractic's Notice of Privacy Practices.

Authorization to Release Information

I authorize Finnigan Chiropractic to discuss my care, appointments, billing, and/or protected health information with the following individuals:

Name	Relationship	Phone Number

I understand I may revoke my authorization to release information to the above-named individuals at any time.

☐ I do not authorize release of information to anyone other than myself.

Communication Preferences

Please select approved/preferred methods of communication:

☐ Phone Call ☐ Voicemail ☐ Text Message ☐ Email

I understand that standard text messaging and email may not always be secure forms of communication.

Patient Name _____

Parent/Guardian Name _____

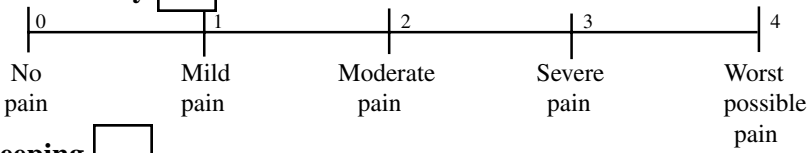
Signature _____ Date _____

Functional Rating Index

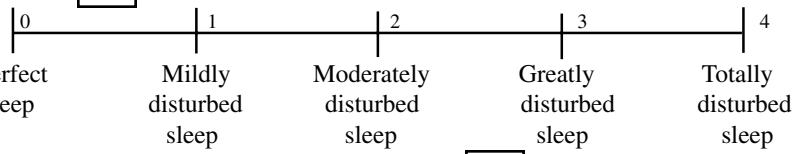
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

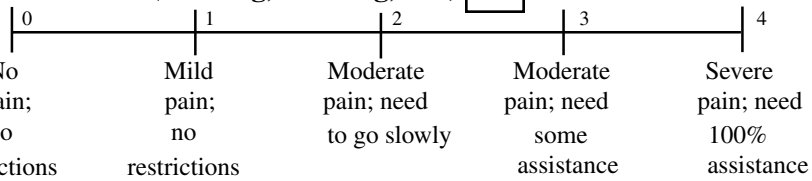
1. Pain Intensity ☐



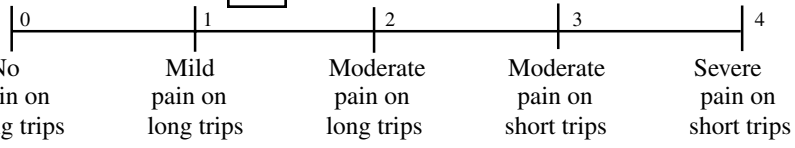
2. Sleeping ☐



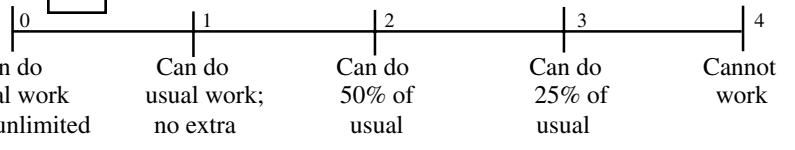
3. Personal Care (washing, dressing, etc.) ☐



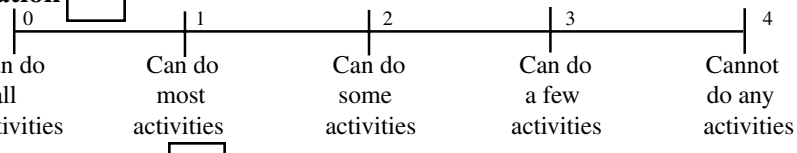
4. Travel (driving, etc.) ☐



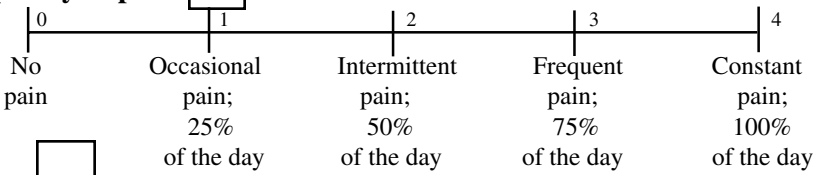
5. Work ☐



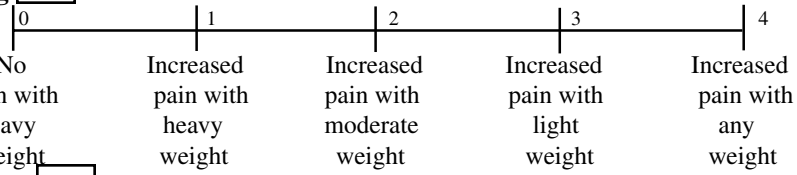
6. Recreation ☐



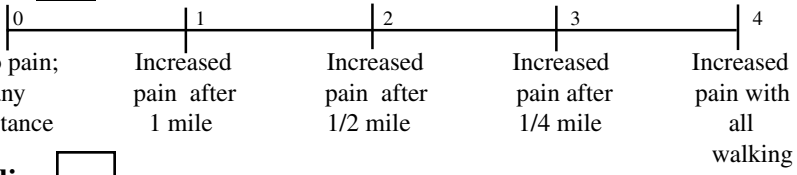
7. Frequency of pain ☐



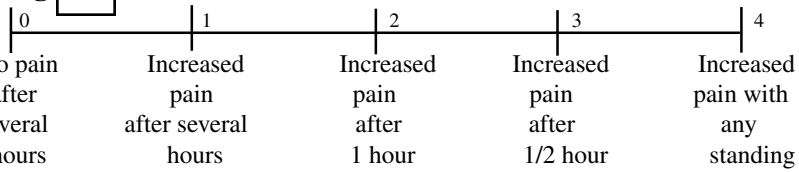
8. Lifting ☐



9. Walking ☐



10. Standing ☐



Total Score _____

Name _____
PRINTED

_____
Signature

_____
Date