Pinehurst Chiropractic

2611 NE 125th St. Suite 115 Seattle WA. 98125 * Phone :(206)365-2233* Fax (206)361-7082

Name_____Date__ ____ _____

Address_____ City/State_____Zip__ _____

For future appointments how would you like to be reminded: Text or Email

CELL PHONE PROVIDER: _____ _____

Home Phone_____Cell Phone _____ Email_____

Sex M F Marital Status: M S D W Date of Birth Age _____

Social Security #_____-_____-_____

Occupation: _____

Employer: _____

Referred by: _____

Have you ever received Chiropractic Care? Yes No If Yes, When?: _____

Previous Interventions, Treatments, Medications, Surgery, or Care for your Complaint(s):
_____

Previous Injury or Trauma (Include Broken Bones & Surgery):_____

_____

Allergies: _____

Current Medications: _____

Pregnancies & Outcomes: _____

Family Health History (Please note any conditions your immediate family has been diagnosed with):

_____

_____

Deaths in immediate family (Include Age & Cause of Death):

_____

_____

David Kirdahy DC

Pinehurst Chiropractic

2611 NE 125th St. Suite 115 Seattle WA. 98125 * Phone :(206)365-2233* Fax (206)361-7082

FINANCIAL POLICY

All fees for services rendered are due at the time of service. The exceptions are: In Network Insurance, Labor & Industry, and PIP. Ultimately, the patient is responsible for all charges incurred at Pinehurst Chiropractic.

CASH PRICE IF PAID AT TIME OF SERVICE

A CHIROPRACTIC ADJUSTMENT, IF PAID AT TIME OF SERVICE INCLUDING EXTREMITIES IS $60.00 ***BILLED $75.00***

A NEW PATIENT EXAM INCLUDING THE ADJUSTMENT $135.00 ***BILLED $205.00***

PAYMENT MAY BE MADE BY CASH, CHECK, VISA, MASTERCARD OR AMERICAN EXPRESS.

MAJOR MEDICAL HEALTH INSURANCE

PINEHURST CHIROPRACTIC WILL SUBMIT CLAIMS TO THE PATIENT'S HEALTH INSURANCE IF WE ARE A PREFERRED PROVIDER. WE ARE CURRENTLY IN NETWORK WITH THE FOLLOWING CARRIERS: **REGENCE BLUE CROSS/BLUE SHIELD.**

WE DO NOT BILL SECONDARY INSURANCE COMPANIES.

PERSONAL INJURY INSURANCE

PINEHURST CHIROPRACTIC WILL SUBMIT CLAIMS TO THE PATIENT'S AUTO INSURANCE COMPANY IF THE PATIENT HAS PERSONAL INJURY PROTECTION (PIP) AND WE HAVE BEEN PROVIDED THE APPROPRIATE INFORMATION FROM THE PATIENT (INS. CO. NAME, BILLING ADDRESS, CLAIM NUMBER, AND ADJUSTER'S NAME). IF THERE ARE NO BENEFITS, THE PATIENT IS RESPONSIBLE FOR ANY AND ALL COSTS ACCRUED.

LABOR AND INDUSTRIES

PINEHURST CHIROPRACTIC WILL SUBMIT ALL CLAIMS TO THE DEPARTMENT OF LABOR AND INDUSTRIES, OR THE APPROPRIATE SELF INSURED COMPANY. IF THE CLAIM IS REJECTED, THE PATIENT IS RESPONSIBLE FOR THE BALANCE.

MEDICARE*

WE ACCEPT MEDICARE BUT YOU MUST PAY AT THE TIME OF TREATMENT. WE WILL BILL MEDICARE FOR YOUR OFFICE VISIT AND, HOPEFULLY, THEY WILL SEND YOU A CHECK COVERING THE ALLOWED AMOUNT. WE CANNOT GUARANTEE THAT THEY WILL COVER THE OFFICE VISIT. THEY ARE SUPPOSED TO SEND THE REIMBURSEMENT CHECK TO YOU, NOT US. **MEDICARE ONLY REIMBURSES FOR ACUTE CONDITIONS, THEY WILL NOT REIMBURSE FOR MAINTENANCE**

MEDICARE FEES:

IF 1 OR 2 REGIONS ARE ADJUSTED $32.50

IF 3 OR 4 REGIONS ARE ADJUSTED OR IF EXTREMITIES ARE INVOLVED $45.00

EXAMINATIONS ARE NOT COVERED BY MEDICARE AND WILL COST $75.00

IN ALL FAIRNESS TO OTHER PATIENTS, WE REQUIRE A 24 HOUR NOTICE OF CANCELLATION.

THERE WILL BE A $30.00 CHARGE FOR CANCELLATIONS WHICH OCCUR LESS THAN 24 HOURS IN ADVANCE AND FOR NO SHOWS.

I, _____, HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE FINANCIAL POLICY, AND KNOW THAT I AM ULTIMATELY FULLY RESPONSIBLE FOR PAYMENT OF MY BILL FOR SERVICES RENDERED AT PINEHURST CHIROPRACTIC. YOUR SIGNATURE BELOW ALSO AUTHORIZES US TO RELEASE ANY PERSONAL AND MEDICAL INFORMATION NECESSARY TO PROCESS YOUR INSURANCE CLAIMS.

PATIENT SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____ _____DATE: _____

*** PRICES SUBJECT TO CHANGE**

David Kirdahy DC

Pinehurst Chiropractic

2611 NE 125th St. Suite 115 Seattle WA. 98125 * Phone :(206)365-2233* Fax (206)361-7082

Review of Systems:

Have you had any of the following pulmonary (lung-related) issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____ □ None of the above

Have you had any of the following cardiovascular (heart-related) issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other _____
□ None of the above

Have you had any of the following neurological (nerve-related) issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo
□ Loss of sense of smell
□ Strokes/TIAs □ Other _____ □ None of the above

Have you had any of the following endocrine (glandular/hormonal) related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes
□ Other _____ □ None of the above

Have you had any of the following renal (kidney-related) issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections
□ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____ □ None of the above

Have you had any of the following gastroenterological (stomach-related) issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation
□ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools
□ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _____ □ None of the above

Have you had any of the following hematological (blood-related) issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive
□ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia
□ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use
□ Other _____ □ None of the above

Have you had any of the following dermatological (skin-related) issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _____ □ None of the above

Have you had any of the following musculoskeletal (bone/muscle-related) issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery
□ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other _____ □ None of the above

Have you had any of the following psychological issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia
□ Psychiatric hospitalizations □ Other _____ □ None of the above

Pinehurst Chiropractic

2611 NE 125th St. Suite 115 Seattle WA. 98125 * Phone :(206)365-2233* Fax (206)361-7082

SYMPTOM 1 _____

1. On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: **1 2 3 4 5 6 7 8 9 10**
2. What percentage of the time you are awake do you experience the above symptom at the above intensity**: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100**
3. When did the symptom begin?

   _____

   a) Did the symptom begin suddenly or gradually? (Circle one)

   b) How did the symptom begin?

_____

4. What makes the symptom worse? (circle all that apply):

   a) Bending neck forward-backward, tilting head to left- head to right, turning head to left-right, bending forward at waist- backward at waist, tilting left at waist- right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe):

   _____

5. What makes the symptom better? (circle all that apply):

   Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, And Other (please describe):_____

   _____

   _____

6. Describe the quality of the symptom (circle all that apply):

   Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, Other (please describe):

   _____

7. Does the symptom radiate to another part of your body (circle one): **Yes No**
   a. If yes, where does the symptom radiate?

      _____

8. Is the symptom worse at certain times of the day or night? (circle one)

   Morning Afternoon Evening Night Unaffected by time of day

Pinehurst Chiropractic

2611 NE 125th St. Suite 115 Seattle WA. 98125 * Phone :(206)365-2233* Fax (206)361-7082

SYMPTOM 2 _____

1. On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: **1 2 3 4 5 6 7 8 9 10**
2. What percentage of the time you are awake do you experience the above symptom at the above intensity**: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100**
3. When did the symptom begin? _____
   a) Did the symptom begin suddenly or gradually? (Circle one)
   b) How did the symptom begin? _____
4. What makes the symptom worse? (Circle all that apply):
   Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe):_____ _____
5. What makes the symptom better? (Circle all that apply):
   Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, other (please describe): _____
6. Describe the quality of the symptom (circle all that apply):
   Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, Other (please describe): _____
7. Does the symptom radiate to another part of your body (circle one): **Yes No**
   a. If yes, where does the symptom radiate? _____
      _____
8. Is the symptom worse at certain times of the day or night? (circle one)
   Morning Afternoon Evening Night Unaffected by time of day

Pinehurst Chiropractic

2611 NE 125th St. Suite 115 Seattle WA. 98125 * Phone :(206)365-2233* Fax (206)361-7082

HIPAA

WE ARE COMMITTED TO PRESERVING THE PRIVACY OF YOUR PERSONAL HEALTH INFORMATION. IN FACT, WE ARE REQUIRED BY LAW TO PROTECT THE PRIVACY OF YOUR MEDICAL INFORMATION AND TO PROVIDE YOU WITH NOTICE DESCRIBING HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

WE ARE REQUIRED BY LAW TO HAVE YOUR WRITTEN CONSENT BEFORE WE USE OR DISCLOSE TO OTHERS YOUR MEDICAL INFORMATION FOR PURPOSES OF PROVIDING OR ARRANGING FOR YOUR HEALTH CARE, THE PAYMENT FOR REIMBURSEMENT OF THE CARE WE PROVIDE YOU, AND THE RELATED ADMINISTRATIVE ACTIVITIES SUPPORTING YOUR TREATMENT.

AS OUR PATIENT, YOU HAVE IMPORTANT RIGHTS RELATED TO INSPECTING AND COPYING YOUR MEDICAL INFORMATION THAT WE MAINTAIN, AMENDING OR CORRECTING THAT INFORMATION, OBTAINING AN ACCOUNTING OF OUR DISCLOSURES OF YOUR MEDICAL INFORMATION, REQUESTING THAT WE COMMUNICATE WITH YOU CONFIDENTIALLY, REQUESTING THAT WE RESTRICT CERTAIN USES AND DISCLOSURES OF YOUR HEALTH INFORMATION, AND COMPLAINING IF YOU THINK YOUR RIGHTS HAVE BEEN VIOLATED.

WE HAVE AVAILABLE A NOTICE OF PRIVACY PRACTICES WHICH FULLY EXPLAINS YOUR RIGHTS AND OUR OBLIGATIONS UNDER THE LAW. WE MAY REVISE OUR NOTICE FROM TIME TO TIME. IN THE EVENT THAT WE DO REVISE OUR NOTICE YOU WILL BE NOTIFIED AND ASKED TO SIGN A NOTIFICATION OF ACKNOWLEDGEMENT OF THE REVISED NOTICE.

YOU HAVE THE RIGHT TO RECEIVE A COPY OF OUR MOST CURRENT NOTICE IN EFFECT. IF YOU HAVE NOT YET RESERVED A COPY OF OUR CURRENT NOTICE, AND WOULD LIKE ONE, PLEASE ASK AT THE FRONT DESK AND WE WILL PROVIDE YOU WITH A COPY.

IF YOU HAVE ANY QUESTIONS REGARDING THIS MATTER OR ABOUT ANY OF YOUR MEDICAL INFORMATION, PLEASE CONTACT OUR OFFICE AT (206) 365-2233.

SIGNED_____ DATE_____

WITNESS_____ DATE_____

David Kirdahy DC