Pinehurst Chiropractic

2611 NE 125th St. Suite 115 Seattle WA. 98125
Text (preferred) 206-201-9085 Office Phone 206-365-2233 Fax 206-361-7082

Name: _____Date:_____

Address: _____

City/State: _____ Zip:_____

Cell Phone:_____ Home Phone:_____

Email:_____

Gender:_____ Marital Status: _____ Date of Birth:_____

Occupation:_____

Employer:_____

Insurance Company:_____

Referred by:_____

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

_____

Previous treatments, medications, surgeries or other therapies:_____

_____

_____

Previous injury or trauma (include broken bones & surgery) _____

_____

_____

Current medications: _____

Pregnancies:_____

Family health history (Please note any conditions your immediate family has been diagnosed with) _____

_____

Deaths in immediate family (include age & cause of death) _____

_____

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Financial Policy

All fees for services rendered are due at the time of service. The exceptions are: In-network insurance, labor and industry, and PIP. The patient is responsible for all charges incurred at Pinehurst Chiropractic.

Fees:	Paid at time of service	Billed
Chiropractic Adjustment, including extremities	$60.00	$75.00
New Patient Exam including an adjustment	$150.00	$210.00 and up

Payment maybe made by cash, check, debit, 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, Premera, and Lifewise. We do not bill secondary insurance companies but we will give you a Super Bill if requested. You can send this into your insurance company for possible reimbursement.

Personal Injury Insurance (PIP):
Pinehurst Chiropractic will submit claims to the patient's auto insurance company if the patient has personal injury protection, (PIP). We will need the appropriate information for the patient including: the insurance company's name, billing address, the claim number, and possibly the 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-insurance company. If the claim is rejected, the patient is responsible for the balance.

Medicare:
We accept Medicare but the patient must pay at the time of treatment. We will bill Medicare for your office visit and, if approved, they will send you a check covering the allowed amount. We cannot guarantee Medicare will cover the office visit. Medicare sends the reimbursement checks to the patient, not our office. In most cases, Medicare only reimburses for acute conditions and will not reimburse for maintenance. Medicare does not pay for the initial examination.
Medicare fees:
If 1 or 2 regions are adjusted $32.50
If 3 or 4 regions are adjusted or if extremities are involved $45.
Examinations are **not** covered by Medicare. The patient is responsible for paying the initial examination fee of $150.00 which also includes the first adjustment.

In all fairness to other patients, we require a 12 to 24 hour notice of cancellation. There will be a $30 charge for cancellations occurring less than 12 hours in advance and for no shows. Text your cancelation at 206-201-9085.

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_____

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Describe 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

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

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Describe 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): 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

If yes, where does the symptom radiate?_____

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

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Describe Symptom #3_____

_____

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

If yes, where does the symptom radiate?_____

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

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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_____