8131 W. Klamath Ct., Ste H.
Kennewick, WA 99336
Phone: (509) 736-5456

Confidential Patient Health Record

Today's Date: ____ / _____ / _____

How did you hear about us? _____

Personal Information

Last Name: _____ **First Name:** _____ **Middle Initial:** ____

Date of Birth: _____ **Sex:** Male / Female **SSN:** _____

Address: _____ **Apt #** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: (_____) _____-_____ **Cell Phone:** (_____) _____-_____

Email: _____ **Would you like TEXT reminders? YES NO**

Cell Phone Provider: _____ I understand that standard text message rates will apply.

Martial Status: Single Married Widowed Divorced Separated Minor

Emergency Contact: _____ **Ph:** (_____) _____-_____

Race: Caucasian Hispanic Asian African American Decline to answer Other

Ethnicity: Caucasian Hispanic or Latino Non-Hispanic or Latino Decline to answer

Preferred Language: English Spanish French Other _____

Employment Information

Employer: _____ **Occupation:** _____

Work Phone: (_____) _____-_____

Health Care Information

Chief Complaints: Neck Pain Lower Back Pain

Upper Back Pain Mid Back Pain Hip Pain

Shoulder/Arm Pain Leg/Knee Pain Headaches

Numbness/Tingling **Other:** _____

Do you have a family doctor? Yes No

Name of Doctor: _____

Are you pregnant? No Yes **Weeks:** _____

Number of children: _____ **Right / Left Handed**

Height: _____ **Weight:** _____

Surgeries in the last 5 years: _____

_____

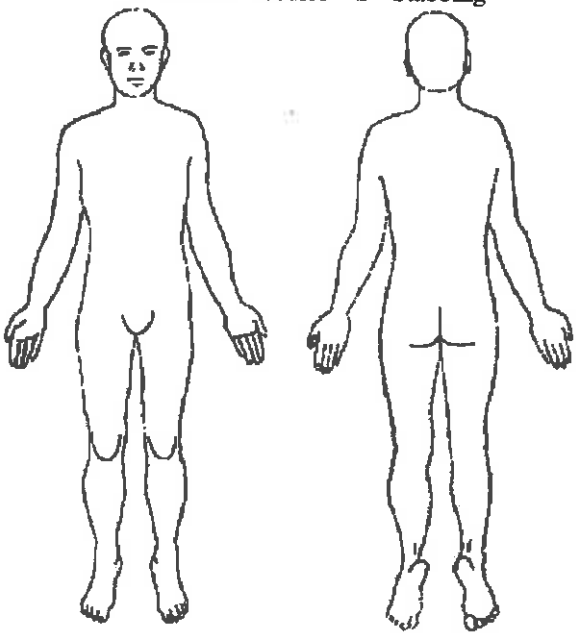
Reason For surgeries: _____

_____

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Key: A= Ache B= Burning N= Numbness

P= Pins & Needles S= Stabbing



Other health problems the doctor should be aware of? _____

_____

When and how did your symptoms start? _____

_____ ☐ **I am interested in massage therapy as a part of my treatment.**

Family History of Illness: _____

Current Medications: _____

Nutritional Supplements: _____

Any Drug Allergies: _____

Social History

Alcohol: Never Socially Occasionally Drinks per day: _____

Tobacco: Never Former Smoker Occasional Smoker Everyday Smoker

Exercise: No **Yes** Hours per week: _____

☐ **I choose to decline an online registration to obtain a clinical summary after each appointment.**
(These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature: _____ **Date:** _____

General/Financial Policy

Welcome to Elite Chiropractic and Massage! We strive to provide you with excellent care in a clean, friendly, professional setting and our goal is to make your visits as convenient as possible.

By signing below, you confirm that you have read this policy and understand that:

- It is your responsibility to inform our office of any address or telephone number changes.
- Your account is to be kept current. All self pay or insurance copayments, co-insurances and deductibles will be collected at the time of service payable by cash, check, Visa or MasterCard.
- If you do not have your payment (s), your appointment may be rescheduled.
- If you are unable to keep a scheduled massage appointment, please notify us no later than 24-hours before so that we may offer that time to another patient. **There may be a charge of $40 for cancellations without proper notification. This charge is not covered by any insurance companies including auto or work injuries.**
- A returned check will result in a $25 service charge.

IF YOU HAVE HEALTH INSURANCE COVERAGE: As a courtesy to you, our office will attempt to pre-verify your insurance coverage for Chiropractic and Massage care. Coverage information is obtained from your insurance company using information provided by you prior to your initial visit. Please be advised that the information provided by your insurance company is not a guarantee of payment, only an estimate of what might be covered under your policy at the time of service.

By signing below you confirm you understand that:

- It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified.
- Not all services are a covered benefit with all insurance plans.
- You are responsible for any non-covered charges not payable by your insurance company.
- Final determination of benefits available is determined when the claim is sent to your insurance company and we receive an explanation of benefits from them.
- After all co-pays, contracted plan reductions and insurance payment credits are applied to your account, any remaining portion will be your responsibility.
- **MEDICARE PATIENTS:** please be advised that Medicare **only covers** Spinal Adjustments in a Chiropractor's office. As a result Medicare New Patient Exams are reduced to $40 and is your responsibility.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, please don't hesitate to ask us.

By signing below, you have read and understand the above policies and agree to meet all financial obligations. The patient also understands and agrees to allow this office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

Signature of Patient/Legal Guardian _____ Date _____

CONSENT TO RELEASE INFORMATION: In the event that you ever wish to have a family member or friend come to our office and get a copy of your medical records for whatever reason, we ask that you sign below allowing them to do so. By signing below I hereby give my consent for Elite Chiropractic and Massage to release my medical records to:

Name of Friend or Family Member _____ Signature of Patient/Legal Guardian _____ Date _____

CONSENT TO TREAT: I consent to chiropractic and massage treatment having been informed of treatment procedure, alternative forms of care and risk of treatment, namely injuries (sprain/strains, broken bones, stroke, etc.) which, although extremely rare, may occur during a chiropractic or massage care.

Printed Name _____ Signature of Patient/Legal Guardian _____ Date _____

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Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosures of your Protected Health Information
Your Protected Health Information will be used by Elite Chiropractic and Massage and the doctors that work within the clinic. It may be disclosed to others for the purposes of treatment, obtaining payment or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy **Policy.** _____ Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use of disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas
Describe and Notify private areas available upon request.

Revocation of Consent
You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

_____ _____
Patient or Legally Authorized Individual Signature Date

_____ _____
Print Patients Name Time

_____ _____
Witness Signature Date