## Patient Profile

Name ______________________________________________ Birth Date ________________________

How you like to be addressed, if different from above ___________________________________________

Address _______________________________________ City ______________ State _____ Zip _______

Social Security # ______ - ______ - ______ E-Mail Address _____________________________________

Home # (___) ________________ Work # (___) _________________ Cell # (___) __________________

Occupation ________________________________ Employer ___________________________________

☐ Male / ☐ Female    Number of Children ___ Names of Children ________________________________

☐ Single ☐ Married ☐ Divorced ☐ Widowed - Name of Spouse/Partner ___________________________

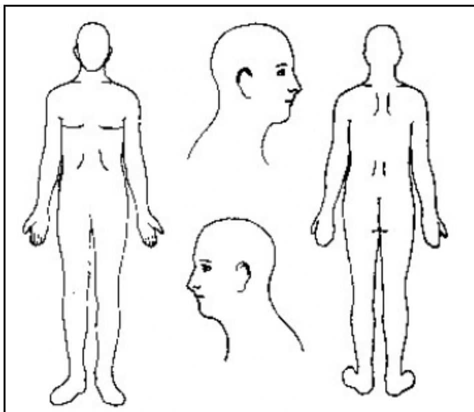
Height ____' ____"    Weight _______ lbs    How did you hear about us?_____________________________

Main reason for consulting our office today? _________________________________________________

______________________________________________________________________________

****Please check if you are here for any of the following: ☐ Car Accident ☐ Work Injury ☐ Other Injury**

Please mark your areas of pain below



Check all that you are currently experiencing (C) or have experienced in the past (P):

| | | |
|---|---|---|
| ☐ Poor Digestion C / P | ☐ Asthma C / P | ☐ Sore Muscles C / P |
| ☐ Ulcers C / P | ☐ Eczema C / P | ☐ Walking Problems C / P |
| ☐ Diarrhea C / P | ☐ Shingles C / P | ☐ Broken Bones C / P |
| ☐ Constipation C / P | ☐ Frequent Colds C / P | ☐ Muscle Cramps C / P |
| ☐ Frequent Heartburn C / P | ☐ Tiredness/Fatigue C / P | ☐ Weak Muscles C / P |
| ☐ Nausea C / P | ☐ Diabetes C / P | ☐ Paralysis C / P |
| ☐ Abdominal Gas C / P | ☐ Blood Pressure – C / P High / Low | ☐ Numbness in Arms C / P |
| ☐ Kidney Infection C / P | | ☐ Numbness in Legs C / P |
| ☐ Menstrual Cramps C / P | ☐ Vision Problems C / P | ☐ Painful Joints C / P |
| ☐ Back Pain C / P | ☐ Ear Pain/Noises C / P | ☐ Stiff Joints C / P |
| ☐ Frequent Urination C / P | ☐ Ear Infections C / P | ☐ Neck Pain C / P |
| ☐ Dizziness C / P | ☐ Hearing Loss C / P | ☐ Shoulder Pain C / P |
| ☐ Fainting C / P | ☐ Poor Coordination C / P | ☐ Mid Back Pain C / P |
| ☐ Forgetfulness C / P | ☐ Seizures C / P | ☐ Low Back Pain C / P |
| ☐ Depression C / P | ☐ Weak Grip C / P | ☐ Hip/ Pelvis Pain C / P |
| ☐ Allergies C / P | ☐ Headaches C / P | ☐ Leg Pain C / P |
| ☐ Hay Fever C / P | ☐ Migraines C / P | ☐ Arm Pain C / P |

☐ Other: ___________________________________________________________

Which of the above symptoms is the worst? (List up to three if necessary) ___________________________

On a scale of 1-10 (1 being very little pain and 10 extreme pain) how would you rate the worst symptom? ______

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This is a ☐ new/ ☐ old condition. It was ☐ not/ ☐ was treated before. If treated before, what was done? _______

_________________________________________

Name of Doctors _____________________________

Have you ever had surgery or been hospitalized? ________

List Surgeries _______________________________

_________________________________________

Have you ever had chiropractic care before? ___________

Name of Doctor ______________________________

Last time you had x-rays_________________________

Medications/Over-the-counter drugs_________________

_________________________________________

_________________________________________

_________________________________________

From birth to present, please list and describe:

1) Car Accidents ________________________

_________________________________________

2) Falls/Injuries ________________________

_________________________________________

3) Sports Injuries _______________________

_________________________________________

4) Other _______________________________

_________________________________________

Family History:

Please list any/ all hereditary conditions you are concerned about: ____________________

_________________________________________

_________________________________________

# Activities/ Daily Living Assessment

Please check all that apply

**Section 1 – Pain Intensity:**
- ☐ Pain comes and goes and is mild
- ☐ Pain is mild and does not vary
- ☐ Pain comes and goes and is moderate
- ☐ Pain is moderate and does not vary much
- ☐ Pain comes and goes and is severe
- ☐ Pain is severe and does not vary much

**Section 2 – Personal Care:**
- ☐ Do not change habits to avoid pain
- ☐ Do not change habits but experience some pain
- ☐ Do not change habits but it increases pain
- ☐ Do change habits due to increased pain
- ☐ Unable to do some personal care without help
- ☐ Unable to wash or dress without help

**Section 3 – Lifting**
- ☐ Lifts heavy weights with no pain
- ☐ Lifts heavy weight with pain
- ☐ Cannot lift heavy weights off the floor
- ☐ Can lift heavy weight from a table
- ☐ Can lift light weights from a table
- ☐ Can lift only very light weights

**Section 4 – Walking**
- ☐ Pain does not prevent walking
- ☐ Cannot walk more than 1 mile
- ☐ Cannot walk more than 1/2 mile
- ☐ Cannot walk more than 1/4 mile
- ☐ Can only walk on crutches
- ☐ Bedridden and must crawl to the toilet

**Section 5 – Sitting**
- ☐ Can sit in any chair as long as desired
- ☐ Can sit only in certain chair as long as desired
- ☐ Can sit no more than 1 hour
- ☐ Can sit no more than 1/2 hour
- ☐ Can sit no more than 10 minutes
- ☐ Cannot sit at all due to pain

**Section 6 – Standing:**
- ☐ Can stand for an unlimited time without pain
- ☐ Some pain standing/ doesn't increase w/time
- ☐ Cannot stand for more than 1 hour
- ☐ Cannot stand for more than 1/2 hour
- ☐ Cannot stand for more than 10 minutes
- ☐ Cannot stand at all

**Section 7 – Sleeping:**
- ☐ No pain in bed
- ☐ Gets pain in bed/ but sleeps well
- ☐ Normal sleep reduced by 1/4
- ☐ Normal sleep reduced by 1/2
- ☐ Normal sleep reduced by 3/4
- ☐ Cannot sleep at all due to pain

**Section 8 – Traveling**
- ☐ Travel without pain
- ☐ Travel causes some pain, but not made worse
- ☐ Causes extra pain, no change in form
- ☐ Causes pain, uses alternative travel
- ☐ Pain restricts all forms of travel
- ☐ Pain restricts travel except lying down

**Section 9 – Social**
- ☐ Normal and causes no pain
- ☐ Normal but causes extra pain
- ☐ Limits energetic interests
- ☐ Pain limits/ does not go out as often
- ☐ Pain restricts social life to home
- ☐ Pain restricts all social life

**Section 10 – Changing Degree of Pain**
- ☐ Pain is rapidly improving
- ☐ Pain fluctuates but is improving
- ☐ Improvement is slow
- ☐ Pain level is unchanged
- ☐ Pain is gradually worsening
- ☐ Pain is rapidly worsening

**Score: _________________ (For Office Use Only)**

# Office Fee Schedule and Financial Policy

## Financial Policy and Chiropractic Active Life Plans

We are committed to providing you with the highest quality chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time the service is rendered unless you arrange a Chiropractic Active Life Plan in advance. These plans are designed to be the most cost effective way to keep you and your family as healthy as possible. Active Life Plans include Corrective Adjustment Plans (CAP) and Wellness Adjustment Plans (WAP). Details of these plans will be discussed with you during your Chiropractic Report.

**Regular Fees:** If you have health insurance that covers chiropractic and choose to us it, you will be charged the regular fees listed above. We will file the insurance claim for you, but please remember that in the event of a dispute, your agreement with your insurance company is between you and them. Any unpaid balances remaining after your insurance claim has been processed will be billed to you. Please note that insurance may not be used for Wellness Adjustment Plans, as most insurance policies do not cover maintenance/ wellness care.

**Time of Service Discounted Fees:** If your health insurance will not cover all of you care, you do not have health insurance, choose not to use your health insurance, or are participating in a Wellness Adjustment Plan, you are eligible to join **ChiroHealth USA** for a membership fee of $39 to receive discounted fees. You will be given a receipt for tax purposes and/or in order to seek reimbursement from a Health Savings Account (HAS), which will indicate the total amount you have paid for chiropractic care during the year. There is no insurance documentation given with these receipts.

We ask that you leave a credit card number on file in the event of any outstanding deductible or copay/coinsurance charges.

☐ Visa ☐ Mastercard ☐ American Express ☐ Discover

Card Number ______________________________ Exp. ______________

We review and evaluate our rates annually, and reserve the right to change fees.
I have read and I understand the above policies.

**Patient Signature** ______________________________ **Date**__________

**PROPERTY OF:**
Vitality Chiropractic
(206) 824-5521

21904 Marine View Drive S
Des Moines, WA 98198

# Terms of Acceptance

When an individual or family seeks, and is accepted for, chiropractic care, it is essential for all parties to be working toward the same objective.

Chiropractic has only one goal. It is important that everyone understands both the objective, and the method that will be used to achieve it. This will prevent any confusion or disappointment.

## Definitions:

**Health:** A dynamic state of wholeness in which your body can accurately perceive its constantly changing needs and respond appropriately in a timely manner. In short, *Health is the ability to adapt* to both internal and external stresses, whether they are physical, chemical, or emotional.

**Subluxation:** A disruption in the normal flow of neurological impulses that the nerves carry between the brain and all the cells of the body. This causes an alteration of the normal physiology and leads to a state of "dis-ease" (the inability of the body to adapt).

**Chiropractic Adjustment:** The specific application of proven gentle force techniques to facilitate the body's correction of subluxation and restore its innate healing processes so as to progressively bring about a state of health and wholeness.

We do not offer to diagnose or treat any disease or condition other than subluxation. However, if during the course of your chiropractic assessment, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will be more than happy to refer you to the appropriate health care provider who specializes in that area.

Regardless of what the "disease" is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **Our Only Practice Objective** is to eliminate symptoms resulting from subluxation. The only method used to accomplish this is the use of the specific chiropractic adjustment to correct the subluxation process.

I, ________________________________________, have read and understand the above.
(Print Name)
All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care for myself and on behalf of my family on this basis.

Signed__________________________________________________ Date ___/___/___

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# Notice of Privacy Practice

**This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your individually identifiable health information. Please review this notice carefully.**

**Privacy:** We are committed to protecting your personal health information against disclosure to unauthorized entities/ persons. With your permission we will share your personal health information only with entities/ persons directly related to your health care and insurance/ payment needs. We will ask for you written permission for any other disclosure of your personal health information.

**Access:** You have the right to review and amend your personal health care records. Fees for copying your personal health information/ records are set by state regulators annually.

**Restrictions:** You have to right to restrict certain uses and disclosures of your protected health information.

**Communications:** You have to right to receive confidential communications from our office. If you would like restricted/ confidential communications from our office, inform our office staff on your first visit and we will make the necessary accommodations.

**Consent:** **I authorize Vitality Chiropractic to share my personal health information <u>only with entities/ persons directly related to my health care and my insurance/ payment needs</u>.**

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to Dr. Bonnie Verhunce at (206) 824-5521.

If you would like further information about our privacy policies and practices please contact Dr. Bonnie Verhunce at (206) 824-5521.

This notice is effective as of April 14, 2003. This notice and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

________________________ ______________________ ____________

Name (printed) Signature Date

If you are a minor, or if you are being represented by another party

________________________ ______________________ ____________

Personal Rep. (printed) Personal Rep. Signature Date

__________________________________________________

Description of the authority to act on behalf of the patient.

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Des Moines, WA 98198

**Patient authorization regarding chiropractic care being provided in an "open adjusting" environment.**

It is the practice of this office to provide chiropractic care in an "open adjusting" environment. "Open adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an "incidental disclosure" of health information. It is our view that the kinds of matters related in an "open adjusting" environment are incidental matters, in the event you or someone else would not agree with us we are providing this disclosure.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an "open adjusting" environment, other arrangements will be made for you. Your decision will have no adverse effect on your care from Vitality Chiropractic.

Your signature indicates your authorization of this activity.

| ______________________ | ______________________ | ____________ |
|---|---|---|
| Name (printed) | Signature | Date |

You may revoke this authorization at any time. Revocation may be accomplished by advising us in writing of your decision to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.

## Legal Assignment of Benefits and Health Insurance Disclosure Agreement

I, the undersigned patient, affirm that I do have insurance and/ or employee medical benefit coverage with an insurance carrier, and I understand and acknowledge that Vitality Chiropractic will bill my insurance carrier for the medical expenses to be incurred while I'm in treatment. Any and all insurance payments and/or insurance reimbursement will be made payable to Vitality Chiropractic by the carrier. If at any time my insurance carrier makes a payment for my care directly to me (instead of Vitality Chiropractic), I agree to honestly and fully pay Vitality Chiropractic for the services rendered. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments or coverage.

I authorize any plan administrator or fiduciary, insurer, and/ or my attorney to release any and all plan documents, insurance policy and/or settlement information to Vitality Chiropractic upon written request. I authorize the use of this signature on all my insurance and/or employee medical benefits claim submissions.

I, the patient, understand that a certain portion of my care may not be covered by or has not been authorized by my insurance plan. I acknowledge that if any portion of the care provided is not, or may not be, covered by insurance, then I will be responsible for payment, and I will make the necessary financial arrangements with my healthcare provider to pay for these services. I understand that Vitality Chiropractic will make every legal effort to receive payment from the carrier for medically necessary chiropractic treatments and I agree to cooperate with my health care provider in any/ all of these attempts, including, if necessary, bringing suit with my insurance carrier at the cost of my provider.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

____________________________________ ________________________
Signature of Insured/Guardian Date

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