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 _____

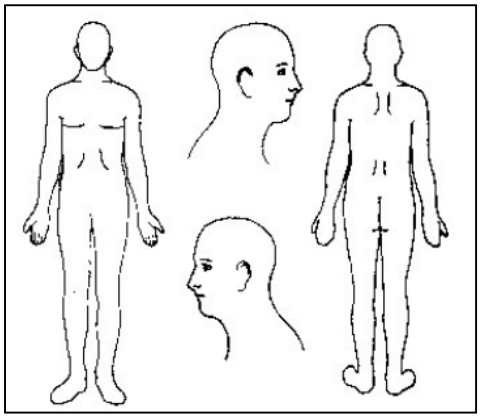
Height ____' ____" Weight _____ lbs How did you hear about us?_____

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

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: _____

_____

_____

Patient Name:_____

Activities/ Daily Living Assessment

Please check all that apply:

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

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

Section 3 – Lifting:
- ☐ I can lift heavy weights with no pain
- ☐ I can lift heavy weights with pain
- ☐ I cannot lift heavy weights off the floor
- ☐ I can lift heavy weight from a table
- ☐ I can lift light weights from a table
- ☐ I can lift only very light weights

Section 4 – Walking
- ☐ My pain does not prevent walking
- ☐ I cannot walk more than 1 mile
- ☐ I cannot walk more than 1/2 mile
- ☐ I cannot walk more than 1/4 mile
- ☐ I can only walk on crutches
- ☐ I am bedridden and must crawl to the toilet

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

Section 6 – Standing:
- ☐ I can stand for an unlimited time without pain
- ☐ I have some pain standing/ doesn't increase w/time
- ☐ I cannot stand for more than 1 hour
- ☐ I cannot stand for more than 1/2 hour
- ☐ I cannot stand for more than 10 minutes
- ☐ I cannot stand at all

Section 7 – Sleeping:
- ☐ I have no pain in bed
- ☐ I have pain in bed but I sleep well
- ☐ My normal sleep is reduced by 1/4
- ☐ My normal sleep is reduced by 1/2
- ☐ My normal sleep is reduced by 3/4
- ☐ I cannot sleep at all due to pain

Section 8 – Traveling (car, bus, plane, etc.):
- ☐ I can travel without pain
- ☐ Traveling causes some pain, but not made worse
- ☐ Traveling causes extra pain, no change in form
- ☐ Traveling causes pain, uses alternative travel
- ☐ My pain restricts all forms of travel
- ☐ My pain restricts travel except lying down

Section 9 – Social
- ☐ I can socialize normally and it causes no pain
- ☐ I can socialize normally but it causes extra pain
- ☐ My pain limits energetic interests
- ☐ My pain limits activity/ I do not go out as often
- ☐ My pain restricts social life to home
- ☐ My pain restricts all social life

Section 10 – Changing Degree of Pain
- ☐ My pain is rapidly improving
- ☐ My pain fluctuates but is improving
- ☐ My pain improvement is slow
- ☐ My pain level is unchanged
- ☐ My pain is gradually worsening
- ☐ My pain is rapidly worsening

Score: _____ (For Office Use Only)

Patient Name:_____

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 state of optimal physical, mental and social well being, not merely the absence of disease of infirmity.

Subluxation: A disruption in the normal flow of Life Energy in the nerves between the brain and 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 gentle force 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 recommend that you seek the services of a 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 a major interference to the full outward expression of your body's Innate Wisdom. Our only method used is specific chiropractic adjusting to correct vertebral subluxations.

I have read and understand the above statement.

Patient/Guardian Signature_____ **Date**_____

Patient Name:_____

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 only with entities/ persons directly related to my health care and my insurance/ payment needs.

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 August 23, 2013. 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.

I have read and I understand the above notice.

Patient/Guardian Signature_____ **Date**_____

Patient Name:_____

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.

I have read and I understand the above policy.

Patient/Guardian 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.

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Vitality Chiropractic as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

INSURANCE COVERAGE
It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations as well as authorization requirements or medical necessity guidelines. This information is furnished by your insurance carrier.
We attempt to verify that your coverage is valid at the time of your visit. However, the ultimate financial responsibility for payment is yours.

INSURANCE CHANGES
If you have had any changes in your insurance coverage - even if there is only a small change in the co-payment amount or a change in the expiration date of the policy - you must notify us. Even a small discrepancy on the chain form can lead to a claim denial.

CO-PAYMENTS, CO-INSURANCE AND DEDUCTIONS
Co-insurance and co-payments are the patient's responsibility. Co-pays are due at the time of visit.
Deductibles are patient's responsibility. The deductible is determined by the contract you have with your insurance carrier- which we strive to know how much each person's deductible is and how much has been met at the time of your visit.
You will be responsible for a $25.00 service fee if your check is returned for nonpayment by the bank.

REFERRALS
It is your responsibility to obtain referrals if required to do so by your plan. We will assist you in obtaining the referral as needed. If your Primary Care physician changes, you must notify us immediately and obtain a new referral.

NON-COVERED SERVICE
All patients are responsible for "non-covered" services if denied by their insurance carrier.

INSURANCE REQUEST
You are responsible for responding to any request from the insurance company for further information. Not doing so will result in a claim denial and you will be responsible for payment.

INSURANCE PAYMENTS SENT TO YOU
If insurance payments are sent to you, you are responsible for forwarding them to our office with a copy of the explanation of Benefits (EOB) received.

COLLECTION ACCOUNTS
In the case your account is forwarded to a collection agency, you are responsible to pay reasonable attorney fees, if applicable.

We emphasize that as a medical care provider, our relationship is with you and not with your insurance company. It is your responsibility to know your policy. Again, we thank you for choosing Vitality Chiropractic as your healthcare provider and are here to help you!

I have read and understand this financial responsibility form.

_____ _____

Patient Signature Date

Patient Name:_____

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.

I have read and understand the above statement.

Patient/Guardian Signature_____ **Date**_____

Methods of Communication

Please use this form to let us know of the method you prefer we use in communicating with you. You have the right to request to receive communications about your protected health information from us by alternative means or at alternative locations and we will accommodate reasonable requests.

Name: _____

Date of Birth: _____ Last 4 digits Social Security # XXX-XX- ____ ____ ____ ____

You may change your mind at any time and we will provide you with another copy of this form to request modification of your preferred method of communication. **You do not need to tell us why you are making this request.**

If You Prefer Email or Text Message

You may request that we communicate with you by email or text message. We must warn you there is some level of risk that protected health information transmitted by unencrypted email or unencrypted text message could be intercepted or read by an unauthorized person. In light of this warning, if you still prefer that we communicate with you by unencrypted email or unencrypted text message we will agree to your request. We are not responsible for unauthorized access of your protected health information while in transmission or for safeguarding information that has been delivered to you.

You may check one or more box below or if your preference is not listed please provide specific directions in the space provided following the check boxes.

I request you communicate with me by:

1. Telephone

- ☐ **Call my Home Phone** - Number _____
  - ☐ Leave message with call-back number with family member or voicemail.
  - ☐ Do NOT leave message with call-back number with family member or voicemail.
- ☐ **Do not contact me on my Home Phone.**

- ☐ **Call my Work Phone** - Number _____
  - ☐ Leave message with call-back number with co-worker or on voicemail.
  - ☐ Do NOT leave message with call-back number with co-worker or on voicemail.
- ☐ **Do not contact me on my Work Phone.**

- ☐ **Call my Cell Phone** - Number _____
  - ☐ Leave message with health information and call-back number on voicemail.
  - ☐ Do NOT leave message with health information and call-back number on voicemail.
- ☐ **Do not contact me on my Cell Phone.**

2. E-mail

I understand there is some level of risk that protected health information transmitted by unencrypted email could be read by an unauthorized person but I still prefer you communicate with me by email at this Email Address:

_____

- ☐ **Do Not contact me by e-mail.**

Methods of Communication

3. Text Message

I understand there is some level of risk that protected health information transmitted by unencrypted text message could be read by an unauthorized person but I still prefer you communicate with me by text message at this cell phone number:

_____

☐ **Do Not contact me by text message.**

4. U.S. Mail

We will send mail to you at your Home Address unless you prefer to receive mail at another mailing address.

☐ Instead of my Home Address, please send mail to me at the address below:

_____

5. Online Communication System via DemandForce

We invite you to participate in our patient online system. Features include but not limited to:

- Receiving Appointment Reminders via E-mail and Text Message
- Requesting Appointments Online
- Confirming Appointments via Email or Text

☐ **I prefer to OPT IN the Online Communication System.**

☐ **I prefer to OPT OUT of the Online Communication System**

6. Other Communication Methods

You may communicate with me as follows (please be specific):

Signature:_____ Date: _____

By signing above, I certify that the information provided is correct and true and I understand that I may my request modification of my preferred method of communication at any time.