Confidential Health History

CLEAR CHIROPRACTIC Upper Cervical Care

Today's Date: _____

Name: _____ SSN: _____ Age: ____

Email: _____ Referred to a certain doctor/LMP? _____

Address: _____ ☐ M ☐ F Date of Birth: _____

City: _____ State: ____ Zip: _____ Occupation: _____

Home Phone: _____ Cell Phone: _____ Employer: _____

Work Phone: _____ Who referred you? _____ Marital Status: _____

Emergency Contact Name: _____ Home Phone: _____

Is your visit due to an auto or work related injury? ☐ Yes ☐ No ***if yes, please get an injury report from front desk***

List authorized person(s) for medical information release: _____

Primary reason for seeking care? _____

Problem started on: _____ Most recent aggravation: _____

What makes it worse? _____

What makes it better? _____

Quality of symptoms:

☐ Aching ☐ Burning ☐ Numbness/Tingling ☐ Stabbing ☐ Dull ☐ Deep ☐ Superficial

If symptoms radiate to other areas, where? _____

Mark Symptoms

☐ No Pain ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Incapacitating Pain

How frequent is it?

☐ Constant(100%) ☐ Frequent(75%) ☐ Intermittent(25%) ☐ Occasional

How long does it last?

☐ 24hrs/day (wakes you at night) ☐ 16hrs/day (does not wake you) Other: ____ hrs/day

HT: ____ in. WT: ____ lbs Hobbies/Sports: _____

List medications: _____

Other doctors used for healthcare: _____

Previous chiropractor(s): _____

All surgeries and dates: _____

Do you have insurance? ☐ Yes ☐ No ***If yes, please give your card to the front desk***

Doctor's Notes

Please Check accompanying Box If Relevant To Your Health History

General

☐ Unexplained Weight/Loss Gain ☐ Fevers/Chills ☐ Recent Trauma

☐ Fatigue ☐ Trouble Sleeping/Sleep Disorder ☐ Past Trauma

Skin

☐ Rashes ☐ Itching ☐ Color Change ☐ New/Change in mole

☐ Lumps ☐ Dryness ☐ Hair/Nail Changes

Head/Eyes/Ears/Ears/Nose/Throat

☐ Visual Changes ☐ Sinus Problems ☐ Hearing Loss ☐ Difficulty Swallowing/Chewing

☐ Double Vision ☐ Head Injury/Trauma ☐ Ringing in Ears ☐ TMJ/TMD ☐ Headaches

Cardiovascular

☐ Chest Pain ☐ Shortness of Breath ☐ High/Low Blood Pressure ☐ Blood Clots

☐ Palpitations ☐ Fainting ☐ Heart Disease ☐ Cold Hands/Feet ☐ Poor Clotting

Respiratory

☐ Cough ☐ Cough Up Blood ☐ TB

☐ Sputum ☐ Asthma/Wheezing ☐ COPD/Emphysema

Gastrointestinal

☐ Abdominal Pain ☐ Vomiting ☐ Diarrhea

☐ Nausea ☐ Constipation ☐ Indigestion

Musculoskeletal

☐ Neck/Back Pain ☐ Stiff Neck ☐ Joint Pain/Stiffness ☐ Hip/Knee/Ankle Pain

☐ Plantar Fasciitis ☐ Scoliosis ☐ Joint Swelling ☐ Shoulder/Elbow/Wrist Pain

Neurologic

☐ Dizziness ☐ Seizures ☐ Weakness ☐ Numbness/Tingling ☐ Migraine/Cluster Headaches

Other

☐ Diabetes ☐ Cancer ☐ Fibromyalgia ☐ Nervous/Anxiety ☐ Depression

☐ Arthritis ☐ Osteoporosis ☐ Varicose Veins ☐ Anaphylaxis

Doctor's Notes

Women Only

☐ Painful Menstruation

☐ Irregular Cycle

☐ Breast Problems

☐ Menopause

Are You Pregnant?

☐ Yes ☐ No ☐ Maybe

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. It is my understanding that my credit may be checked if Clear Chiropractic extends credit to me and I understand that if I suspend or terminate my care, fees for professional services rendered to me will be immediately due and paid unless other arrangements are made. I hereby authorize the doctors of Clear Chiropractic and whomever they may designate as their assistants to administer treatments as they so deem necessary and also authorize the release of any information acquired in the course of examination or treatment. I certify that the above information is true and correct.

Signed By (please print)

Signature Date

Clear Chiropractic
Notices of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Clear Chiropractic is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations (example),
"On occasion, it may be necessary to seek consultation regarding your treatment from other health care providers associated with Thrive Chiropractic"

"It is our policy to provide a substitute health care provider, authorized by Clear Chiropractic to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness or other emergency situation."

Due to the nature of Clear Chiropractic's open adjustment areas, others may overhear conversations between the doctor and patient although every effort will be made to avoid loss of confidentially. At any time you may request a private consultation with the doctor.

Payment
We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (Example)

"As a courtesy to our patients, we will submit an itemized statement to your insurance center for the purpose of payment to Clear Chiropractic for health care services rendered. If you pay for your health care services personally we will, as a courtesy to you, provide and itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information including diagnosis, date of injury or condition, and codes which may describe the health care services received."

Worker's Compensation
We may disclose your health information as necessary to comply with State Workers compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member or another person responsible for your care about your medical condition or in the event of an emergency or your death.

Public Health
As required by law, we may disclose your health information to public health authorities for the purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infectious exposure.

Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement
We may disclose your health information to law enforcement officials for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order of subpoena, and other law enforcement purposes.

Deceased Persons
We may disclose your health information to coroners or medical examiners.

Organ Donation
We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

Research
We may disclose your health information to researchers conducting research that has been approved by the Institutional Review Board.

Public Safety
It may be necessary to disclose your health information to appropriate persons in order to prevent or lesson a serious and imminent threat to the health or safety of a particular person or to the general public

Specialized Government Agencies
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing
We may contact you for marketing purposes or fundraising purposes, as described below: (example)

"As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not home, we will leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.
"It is our practice to participate in charitable events to raise awareness, food donations, etc. During these times, we may need to send you a letter, post card or call your home to invite you to participate in the charitable activity.We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Clear Chiropractic sponsored fund- raising events."

Change of Ownership
In the event that Clear Chiropractic is sold or merged with another organization, your health information will become the property of the new owner.

Your Health Information Rights

- *You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Clear Chiropractic is not required to agree to the restriction you requested.*
- *You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.*
- *You have the right to inspect and receive a copy of your health information.*
- *You have the right to request that Clear Chiropractic amend your protected health information. Please be advised, however, that Clear Chiropractic is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.*
- *You have the right to receive an accounting of disclosures of your protected health information made by Clear Chiropractic*
- *You have the right to a paper copy of this Notice of Privacy Practices at any time upon request.*

Changes to this Notice of Privacy Practices
Clear Chiropractic reserves the right to amend this Notice of Privacy Practices at any time in the future and will make the new provisions effective for all the information that it maintains. *Until such an amendment is made, Clear Chiropractic is required by law to comply with this Notice. (Continued)*

(cont'd) Clear Chiropractic is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact Roxanne McMurtry by calling 425-861-8837. If she is not available you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy rights or how Clear Chiropractic has handled your health information should be directed to Roxanne McMurtry by calling 425-861-3832. If she is not available you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, SW Room 509F HHH Building Washington, D.C. 20201

This notice is effective as of (01/14/2010)

I have read the Privacy Notice and understand my rights contained in the notice

By way of my signature, I provide Clear Chiropractic with my authorization and consent to use and disclose my protected health care information for the purposes of the treatment, payment and health care operations as described in the Privacy Notice.

Patient Name (please print) _____

Patient Signature Date Patient Signature Date

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is be specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination, 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 expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____, have read and fully understand the above statements.

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 on this basis.

Patient Name (please print) _____

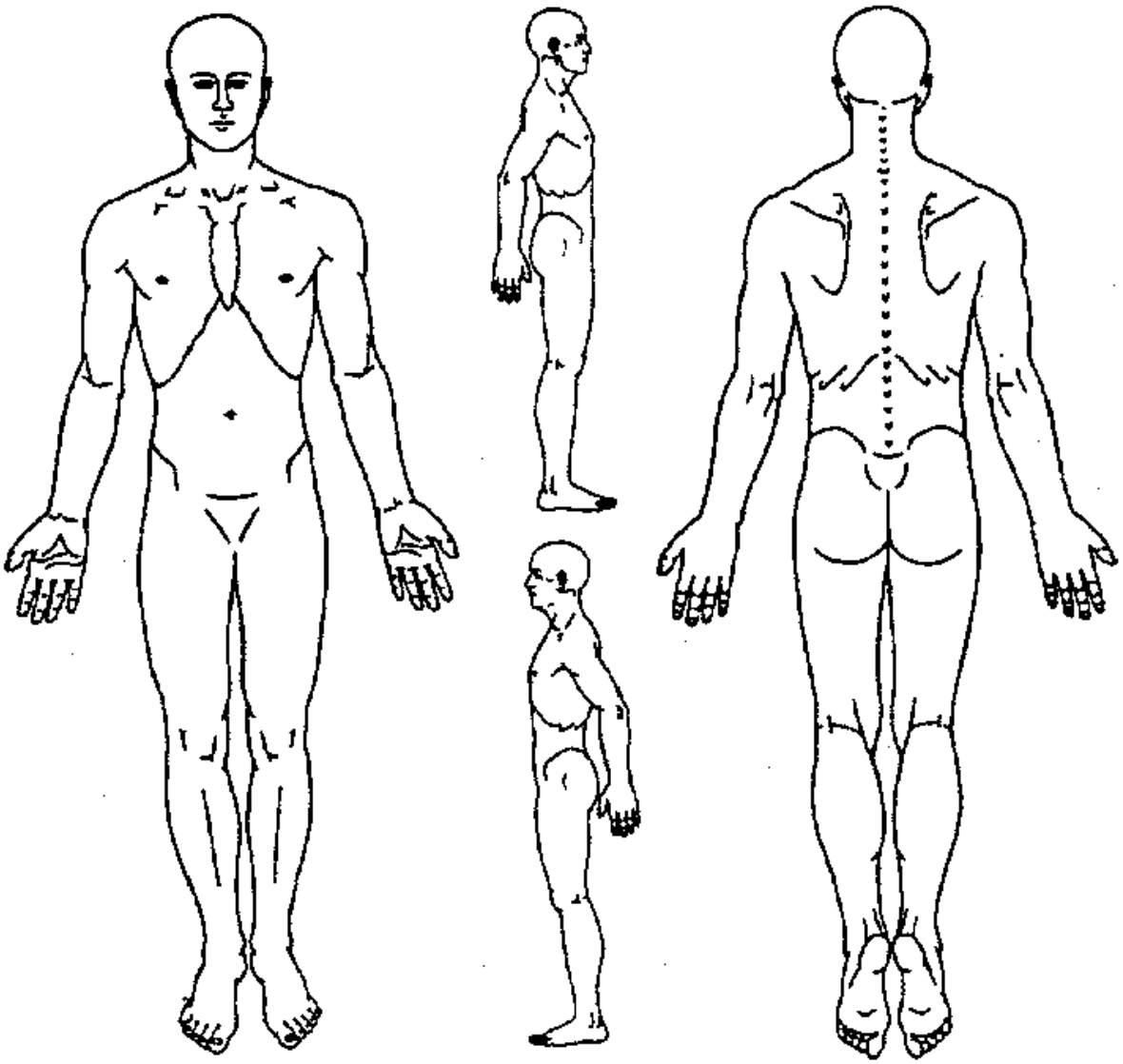
Patient Signature Date

Pain Diagram

Name: _____

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

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - -	o o o o o	^ ^ ^ ^ ^	x x x x	⊗⊗⊗⊗
- - - - - -	o o o o o	^ ^ ^ ^ ^	x x x x	⊗⊗⊗⊗
- - - - - -	o o o o o	^ ^ ^ ^ ^	x x x x	⊗⊗⊗⊗



Cancellation Policy

(Redmond and Spokane Offices)

Our office requires at least 24 hours notice if you need to cancel or change a massage appointment. If less than 24 hours notice is given, you will be charged for your appointment in the amount of $45.00. This fee is not covered by your insurance, and is your responsibility to pay immediately. We understand emergencies do occur and in special circumstances this fee may be waived.

I have read and understand the above information.

Name (please print): _____

_____

Signature Date

Cancellation Policy

(Kirkland Office Only)

Our office requires at least 48 hours notice if you need to cancel or change a massage appointment. If less than 48 hours notice is given, you will be charged for your appointment in the amount of $45.00. This fee is not covered by your insurance, and is your responsibility to pay immediately. We understand emergencies do occur and in special circumstances this fee may be waived.

I have read and understand the above information.

Name (please print): _____

_____

Signature Date