Patient Registration

Family Chiropractic
Ron Wilcox, D.C.
204 Pinehurst Dr. SW, Ste. 103, Tumwater, WA 98501
Tel: (360) 352-8112 • Fax: (360) 352-8113

First Name:_____ MI: ____ Last Name:_____

DOB: ____/____/_____ Age: _____ Gender: ❑ Male ❑ Female SSN: _____

Name Suffix: ❑ Jr. ❑ Sr. *(If applicable)*

Address 1: _____ Address 2: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Mobile Phone: _____

Work Phone: _____

Personal Email: _____

Preferred Communication: ❑ Phone ❑ Mail/Letter ❑ Email ❑ Fax ❑ Decline

Confidential Communications: ❑ Home ❑ Work ❑ Mobile ❑ Email ❑ Mail ❑ Decline

How would you like to receive appointment reminders?
❑Text Message ❑Email ❑I choose to decline appointment reminders.

Marital Status: ❑ Single ❑ Married ❑ Other

Employment Status: ❑ Employed ❑ FT Student ❑ PT Student ❑ Retired ❑ Self Employed ❑ Other

Professional Title: _____ Employer: _____

Employer Address: _____ City:_____ State:_____ Zip: _____

Emergency Contact: _____ Relationship to Patient: _____

Home Phone: _____ Mobile Phone: _____

Who is your Primary Care Physician? _____
Practice name? _____

Whom may we thank for referring you? _____
Can we send them a thank you note for referring you to us? Yes or No

Patient Demographics:

Race: *(check one or more)* ❑ White ❑ American Indian/Alaskan Native ❑ Black/African American ❑ Native Hawaiian or other Pacific Island ❑ Asian ❑ Decline

Ethnicity: *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Decline

Preferred Language: *(list)*_____ ❑ Decline

Smoking: *(check one)* ❑ Current Sometimes Smoker ❑ Never Smoker ❑ Smoker, Current Status Unknown ❑ Unknown if Ever Smoked ❑ Heavy Smoker ❑ Light Smoker
❑ Current daily Smoker: What is the frequency that you smoke? _____ Packs/Day
❑ Former Smoker: Smoking End Date: _____ ❑ Decline

Exercise: *(check one)* ❑ None ❑ Moderate ❑ Daily ❑ Heavy

Work Activity: *(check one)* ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

Habits: *(check one)* ❑ Alcohol: Drinks/week _____ ❑ Coffee/Caffeine: Cups/day _____ ❑ High Stress Level

Female: Are you pregnant? ❑No ❑ Yes, Due Date: _____ Last Pelvic Exam: _____

Briefly list your main health problems:

1. _____
2. _____
3. _____
4. _____
5. _____

List any known allergies:

1. _____
2. _____
3. _____
4. _____
5. _____

Do you carry an Epipen? ☐ Yes ☐ No

Current Prescribed Medications: **Vitamins/Supplements, include dosage if known:**

Name:	Dosage:	Name:	Dosage:
1.		7.	
2.		8.	
3.		9.	
4.		10.	
5.		11.	
6.		12.	
7.		13.	

Do you have a personal or family history of diabetes, heart problems, high blood pressure or other systemic illnesses?

_____

_____

Injuries/Surgeries you have had:

Fall: _____ Description: _____ Date: _____
Head Injuries: _____ Description: _____ Date: _____
Broken Bones: _____ Description: _____ Date: _____
Dislocations: _____ Description: _____ Date: _____
Surgeries: _____ Description: _____ Date: _____

Please check to indicate if you have/had any of the following:

☐AIDS/HIV
☐Alcoholism
☐Allergy Shots
☐Anemia
☐Anorexia
☐Appendicitis
☐Arthritis
☐Asthma
☐Bleeding Disorders
☐Breast Lump
☐Bronchitis
☐Bulimia
☐Cancer
☐Cataracts
☐Chemical Dependency
☐Chicken Pox
☐Diabetes
☐Emphysema
☐Epilepsy
☐Glaucoma
☐Goiter
☐Gonorrhea
☐Gout
☐Heart Disease
☐Hepatitis
☐Hernia
☐Herniated Disk
☐Herpes
☐High Cholesterol
☐kidney disease
☐Liver Disease
☐Measles
☐Migraine Headaches
☐Miscarriage
☐Mononucleosis
☐Multiple Sclerosis
☐Mumps ☐Osteoporosis
☐Pacemaker ☐Parkinson's Disease
☐Pinched Nerve
☐Pneumonia
☐Polio
☐Prostate Problems
☐Prosthesis ☐Psychiatric Care
☐Rheumatoid Arthritis
☐Rheumatic Fever
☐Scarlet Fever
☐Stroke
☐Suicide Attempt
☐Thyroid Problems
☐Tonsillitis
☐Tuberculosis
☐Tumors
☐Typhoid Fever
☐Ulcers
☐Venereal Disease
☐Whooping Cough

☐Other: _____

What is your main concern for today's visit? _____

How did this start? _____
Is the pain: ❑ Better ❑ Worse ❑ About the Same
When did it start? _____
Is the pain constant? ❑Yes ❑No If not, when is it worse? _____
What makes the pain worse? _____
What makes the pain better? _____
What treatment have you received? _____
Have you seen a Chiropractor before? ❑ Yes ❑ No
If yes, who? _____ How long ago? _____

On the pictures below, use the key on the left to shade in the areas where you are currently experiencing discomfort:

Key:

Numbness
- - - - - - -

Pins and Needles
Oooooooo

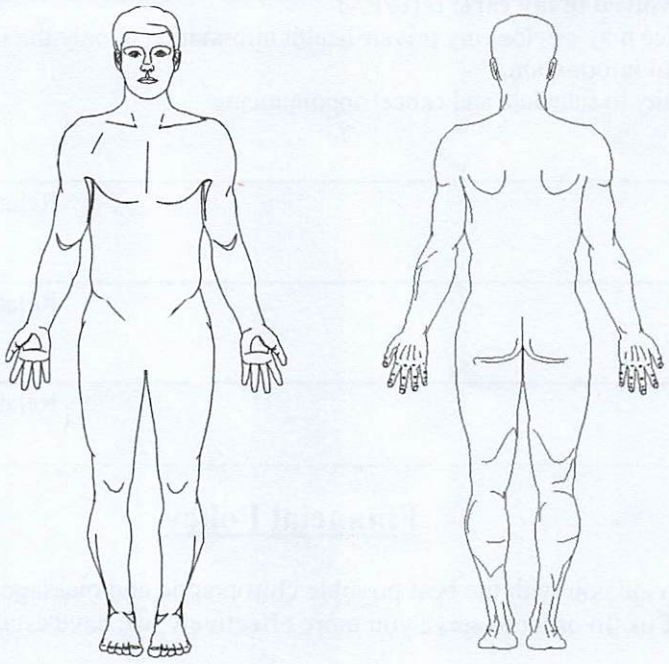
Burning

xxxxxxxx

Stabbing/Sharp
//////////////

Aching/Dull
****

Popping/Clicking
P P P



INFORMED CONSENT

A patient, in coming to Family Chiropractic, gives the doctor permission and authority to care for the patient in accordance with chiropractic tests, diagnosis, and analysis. The chiropractic adjustment/massage or other clinical procedures are usually beneficial and seldom cause problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or provide health care, if he is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the Doctor of Chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Doctor of Chiropractic provides a specialized health service. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, massage therapy and diagnostic x-rays on me (or for the patient for whom I am legally responsible) by Family Chiropractic and/or by other licensed Doctor of Chiropractic who now or in the future will treat me while employed by, working with, or associated with Family Chiropractic.

Patient/Legal Representative Signature Date

NOTICE OF PRIVACY PRACTICE

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your records to get information about it by contacting our office at 360-352-8112. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed and how you may access your information.

Patient/Legal Representative Signature Date

Printed Name if signed on behalf of patient Relationship

DISCLOSURES TO FAMILY AND/OR FRIENDS DOCUMENTATION FORM

Family Members/Friends Involved in my care: (HIPPA)

1) I agree that this office may disclose my private health information to only the following individuals listed below.
2) Allow them financial information.
3) Allow them the ability to schedule and cancel appointments.

_____

Name Relationship

_____

Name Relationship

_____

Name Relationship

Financial Policy

Welcome! Our goal is to provide you with the best possible chiropractic and massage care, and to have a pleasant, positive, experience for all of us. In order to serve you more effectively, we have established a few policies.

APPOINTMENTS: Your appointments are times reserved and committed exclusively to you. We realize emergencies do occur, and appointments must sometimes be changed. Charges MAY be made for missed appointments and appointments cancelled without two hours' advanced notice. (Initial)_____

INSURANCE: We must emphasize that as chiropractic and massage providers, our primary relationship is with you. As a service to our patients, we do accept assignment of insurance benefits of most policies. In addition, we are participating providers with several insurance carriers and payers. YOU are responsible for payments of your co-pay at the time of service. If your deductible has not been met, YOU are responsible for full payment until it has been met; then, only your part thereafter. Once the claim has been processed by your insurance provider, we will bill you your patient responsibility part. Payment is due within 30 days of the bill. (Initial)_____

****NOTE:** *We are happy to assist you in verifying your chiropractic and massage benefits, all insurance companies begin verification with a message which states: 'This verification of benefits is not a guarantee of payment. This is a simple overview of the policy. Only when a claim is received can it be reviewed for medical necessity and for policy provisions. Again, this is not a guarantee of payment."***

I RECEIVED A BILL EVEN THOUGH I HAVE SECONDARY INSURANCE: Having secondary insurance does not necessarily mean that your services are 100% covered. Secondary insurance policies typically pay according to a coordination of benefits with the primary insurance.

WHAT IF FAMILY CHIROPRACTIC DOES NOT CONTRACT WITH MY PLAN OR I DON'T HAVE INSURANCE: If we are not a provider under your insurance plan or you don't have insurance, you will be responsible for payment in full at the time service. You will be charged our office's time-of-service rates. At the sole discretion of the practice, extended payment agreements may be made for patients. Please speak to our office manager to discuss a mutually agreeable payment plan. It is never out intention to cause hardship to our patients, only to provide them with the best care possible and reasonable costs.

PAYMENTS: Payment is due at the time the services are rendered, unless other arrangements have been made in advance. We accept cash, check, Visa/MasterCard, Discover/American Express. Returned checks are subject to a $30.00 service charge. Any account that becomes will be subject to collections service. Should our clinic receive information that your insurance will no longer be covering services, such as in the incidence of maximum insurance payout met, you will be charged the applicable discounted to time-of-service rates and supplied receipts if needed. (Initial)_____

Credit/Debit Card Authorization

Patients are responsible for all charges and services that are not covered by their insurance provider. In accordance with our office's payment policies, we ask that you review the following terms and conditions and provide an alternative payment method.

1. I understand that the Provider will submit all billing claims to my insurance provider for reimbursement, but I am solely responsible for all charges and services I receive from this Provider, including those covered by my insurance.
2. I understand that payment may be expected at the time of service. This may include a co-pay and additional payment if this practice decides that the cost of my visit today will not be reimbursed by my insurance provider.
3. I understand that I may be charged a service fee, or service may be denied for failure to pay co-pay or any outstanding balance at the time of service.
4. I understand that it is my responsibility to ensure that the Provider always has current information on file, including my address, contact details, insurance information and a valid credit/debit card or other payment information.
5. I understand that my signature and payment information will be held on file for future use by the Provider.
6. I understand that I may receive a monthly statement any outstanding balance that is not satisfied by a charge to payment method and that I am responsible for paying this balance by its due date.
7. I understand that unpaid balances may incur additional fees and interest charges.
8. I authorize Family Chiropractic to send electronic account statements, invoices, and receipts to the email address I have provided to the office. I understand that it is my responsibility to maintain a current email address on file and that I will not receive a mailed copy of any electronic statement.
9. I authorize Family Chiropractic to send me a text message of my current balance that is due, and I may request a statement be emailed to me at the email address I have provided to this office.
10. I understand this authorization will remain in effect until the expiration of the credit card or until I provide a 30-day written notice of cancellation to Family Chiropractic.

Acknowledgement and Authorization:
I have read all the information on this form and have completed on this form and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify Family Chiropractic IMMEDIATELY of any changes in my health status or the above information, including changes of insurance policies.

By signing this form, I acknowledge that I have received, reviewed, and understood Family Chiropractic's payment policies. I authorize Family Chiropractic to charge my card in accordance with the payment policy. I certify that I am an authorized cardholder or user of this credit/debit card.

Name (print) _____

Signature _____

CC Type _____ CC Number _____

CC Expr date _____ CC CVC Code _____

Approval to keep CC on file in the computer system (signature)_____

Signature if patient is a minor:_____ Date_____

Relationship if patient is a minor:_____