SEATTLE FAMILY CHIROPRACTIC

***<u>**Please complete each line on this form or write N/A if the line is not applicable to you.**</u>

Patient Name:_____
(FIRST) (MI) (LAST)

Patient DOB: _____ Marital Status: S M D W

Is the patient a child/minor? ☐ Yes ☐ No If YES, name of parent:_____

Address: _____

Cell: _____ Work: _____

Email address: _____ Home: _____

Employment: ☐ Unemployed ☐ Full-time ☐ Part-time ☐ Retired ☐ Student

Present Employer:_____ Occupation:_____

Primary Care Physician:_____ Phone: _____

Emergency Contact: _____ Phone: _____

How did you hear about our practice? _____

****Patient Signature: X_____ Date: _____**

****If the patient is a minor, this signature authorizes Seattle Family Chiropractic, PLLC to provide care to a minor and bill the insurance company directly.**

Seattle Family Chiropractic, PLLC
2202 8th Ave., Suite 1103 ● Seattle, WA 98121 ● Phone 206-405-3333
Jill S. Goldberg, D.C. ● NPI 1801935689 ● Group NPI 1023443264

HEALTH INSURANCE INFORMATION

☐ **No Health Insurance and/or No Chiropractic Coverage, Self Pay/Cash**

Insurance Company:_____ ID # _____ Group # _____

Policy Holder name: _____ Policy Holder date of birth: _____

Policy Holder's relationship to you (Self/Spouse/Parent etc.):_____

Amount of deductible: $ _____. Amount met to date: $ _____. Copay: $_____ ***or*** Co-insurance: ____%.

Does your medical deductible apply to chiropractic care? YES ___ NO ____

Calendar month your policy period begins: _____. Number of visits per year allowed:_____

Does your insurance plan require prior authorization? YES ___ NO ____

If YES: 1) Name and phone number of agency: _____

2) When is prior authorization required? Before the first visit? _____After the _____th visit.

Please call your insurance company to obtain the above information and fill out above form completely.

****Please bring your insurance card and your driver's license with you to your appointment.****

HEALTH INFORMATION - Complete each line below or write "N/A" if not applicable

Childhood Years:

Traumatic birth process? _____ Medical problems/Ear infections?_____

Falls or other traumas? _____

Adult Years: (Please list dates)

Falls or other traumas? _____

Medical Conditions? _____

Sports Injuries? _____

Auto Accidents? #1 Date: _____ Treatment/Length of Treatment:_____

#2 Date: _____ Treatment/Length of Treatment:_____

****Patient Signature: X_____ Date:** _____

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Medications/Reason for taking?

#1: _____ Reason for taking: _____

#2: _____ Reason for taking: _____

#3: _____ Reason for taking: _____

#4: _____ Reason for taking: _____

Surgeries? Date and type of surgery: _____

_____

Pregnancies/dates? _____

Family history/prevalent diseases?_____

_____

Lifestyle: Alcohol: _____ Tobacco: _____

Hobbies:_____

Level of exercise: _____

Diet: _____

Stress: Physical (i.e. daily activities, hobbies, repetitive motion, lifting etc.): _____

Emotional ☐ None ☐ Low ☐ Moderate ☐ High ☐ Depression ☐ Anxiety

Chemical (i.e. vitamins/supplements, medication, alcohol, lack of water, junk food): _____

_____

What type of work do you do? _____

Do you sit or stand at work? _____

Recreational activities? _____

What position do you sleep in? (Check all that apply) ☐ Back ☐ Stomach ☐ Side

****Patient Signature: X**_____ **Date:** _____

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Have you been to a chiropractor before? ☐ YES ☐ NO **Date of Last visit**? _____

Length of treatment: _____

Reason for treatment : _____

Is this visit due to a recent Workers' Compensation injury? ☐ YES ☐ NO Date: _____

Is this visit due to a recent automobile accident? ☐ YES ☐ NO Date: _____

What other specialists have you seen for this condition? _____

_____

Have you had radiographs of your spine within the last 10 years? ☐ YES ☐ NO

X-Ray Date: _____ Facility: _____

X-Ray Date: _____ Facility: _____

MRI Date: _____ Facility: _____

CT Scan Date: _____Facility: _____

What areas were x-rayed? ☐ Neck ☐ Mid Back ☐ Lower Back ☐ Additional Areas

_____

_____

****Patient Signature: X_____ Date:** _____

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Please rate the below symptoms and/or pain areas (that apply to you) **on a scale of 1-10 with 1 being the least severe and 10 being the most severe**. Please also include mild pain areas as well.

_____ No pain/symptoms. I want to get adjusted to stay well and will *not be using my health insurance since this will be considered maintenance chiropractic care which is not covered.*

_____ Neck Pain – Approximate Date Pain Began: _____

_____ Upper back pain– Approximate Date Pain Began: _____

_____ Shoulder joint pain– Approximate Date Pain Began: _____

_____ Mid back pain – Approximate Date Pain Began: _____

_____ Headaches – Approximate Date Pain Began: _____

_____ Radiating pain down arm from neck – Approximate Date Pain Began: _____

_____ Numbness/tingling describe area – Approximate Date Pain Began: _____

_____ Radiating pain down legs: describe area _____

Approximate Date Pain Began: _____

_____ Low back pain – Approximate Date Pain Began: _____

_____ Hip pain – Approximate Date Pain Began: _____

_____ Knee pain – Approximate Date Pain Began: _____

_____ Asthma – Approximate Date Pain Began: _____

_____ Allergies – Approximate Date Pain Began: _____

_____ Muscle tenderness, describe area: _____

Approximate Date Pain Began: _____

_____ Tiredness/Low Energy– Approximate Date Pain Began: _____

_____ Difficulty Walking – Approximate Date Pain Began: _____

_____ Other radiating pain: Area From _____ Area To _____

Approximate Date Pain Began: _____

Other Complaints _____

_____

****Patient Signature: X_____ Date: _____**

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FOR ALL PATIENTS WITH INSURANCE

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE.

I, the undersigned, authorize direct payment of healthcare benefits to Seattle Family Chiropractic, PLLC for any services furnished to me. I understand that I am financially responsible for any amount not covered by my insurance company. I authorize you to release to my insurance company information concerning healthcare, advice, treatment, or supplies, provided to me. I authorize my insurance company and other healthcare providers to release information concerning healthcare, advice, treatment, or supplies provided to me to Seattle Family Chiropractic, PLLC.

Please note that professional services are rendered and charged to the patient and not to the insurance company. Any co-pays and/or co-insurance amounts and/or deductibles are due at the time that services are rendered. **If your plan requires a referral or prior authorization, you must notify our office with details. You are responsible for verifying coverage with your insurance company**. Information provided by this office does not determine actual benefits payable by your insurance company. Your insurance company determines actual benefits for provided services when claims are submitted. You are responsible for any services provided that are not covered by insurance. This office cannot accept responsibility for collecting your insurance claim/claims or for negotiating a settlement on any disputed claim/claims that our office has submitted for services rendered on your behalf. Please be aware that insurance covers care for acute conditions only. We offer various affordable payment plan options for those who do not have insurance coverage. Dr. Goldberg will review those with you at the time of your visit.

****Patient Signature: X_____ Date: _____**

OFFICE POLICIES

Our mission is to provide high quality chiropractic care at an affordable cost. In order to accomplish this goal, we ask you for the courtesy of ***24 hours notice for cancellations and rescheduling*** **of appointments.** Seattle Family Chiropractic, PLLC reserves the right to charge a $50 fee for appointments *cancelled with less than 24 hours notice*. All cancellations and appointment time changes must be **made via phone only at 206-405-3333, <u>not via text or email</u>**. At our sole discretion, as a courtesy, we may elect to waive the $50 cancellation fee when re-booking within the same week.

I have read the above polices and I accept the terms outlined. I understand and accept my financial responsibility to Seattle Family Chiropractic, PLLC. We reserve the right to charge 1.5% interest per month on unpaid balances and 2.75% square credit card fee for credit card use. I understand that treatments in this office are for the purpose of removing nerve interference in my body by correcting vertebral misalignments (AKA subluxations). I understand that Seattle Family Chiropractic, PLLC and Dr. Jill Goldberg does not treat or diagnose any medical conditions for the purpose of diagnosing the cause of pain. If I have concerns about a medical condition, I take responsibility for contacting my medical doctor for a diagnosis.

****Patient Signature: X_____ Date:_____**

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AUTHORIZATION/HIPPA FORM POLICY

Effective date of policy: Jan 1, 2018

Protected health information (PHI) will only be released from our practice with a properly executed authorization from the patient or his/her personal representative, except for treatment, payment, or health care operations (TPO) and as otherwise required by law. Examples of some instances in which we are required to disclose your PHI include:
Public health activities; information regarding victims of abuse, neglect, or domestic violence; health oversight activities; judicial and administrative proceedings; law enforcement purposes; organ donations purposes; research purposes under certain circumstances; national security and intelligence; correctional institutions; and Worker's Compensation.

Seattle Family Chiropractic, PLLC will only use or disclose PHI, except as noted above, consistent with the terms of the authorization.

A patient may revoke his authorization to use or disclose PHI at any time but actions taken prior to the revocation are excluded. If authorization is a condition of obtaining insurance coverage, and the authorization is revoked, the insurer may contest a claim under the policy.

Authorizations must be properly executed by the patient or his personal representative. It should include, the date signed, specific PHI to be released or used, to whom this use or release relates, and an expiration date for the authorization.

Patient Signature: X_____ Date: _____

Patient Name Printed: _____

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