Devine Chiropractic and Rehab Center

Today's Date_____

About You

Name _____ What You Prefer to Be Called_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone _____ Other_____

Birth Date_____ Age_____ Gender (check one) ○Female ○Male

SSN#_____ Drivers License _____Email_____

Occupation_____Employer_____ How Long?_____

Employer's Address_____ City__ _____ State____ Zip_____

Status (check one) ○Minor ○Single ○Married ○Divorced ○Separated ○Widowed

Spouse/Partner Name_____ Do you have children? ○Yes ○No How Many? _____

How did you hear about our office? _____

Emergency Contact Name_____ Relation_____

Home Phone_____ Cell Phone _____ Other_____

Name of Medical Doctor_____Phone_____

Reason for Visit

Is your condition a result of: ○Work ○Auto Accident ○Trauma ○Chronic ○Other _____

Briefly describe what happened:_____

_____

_____

When did this condition begin?_____ Is it getting better or worse?_____

Have you had a similar condition in the past? ○Yes ○No

Have you seen any other doctors for this condition? ○Yes ○No If Yes whom?_____

Have you ever had chiropractic care before? ○Yes ○No

If yes whom? _____Phone_____

Health History

Please list any surgeries/hospitalizations that you have had and the dates:_____

_____

Please list serious past injuries and the dates:_____

_____

Please list all serious medical conditions/allergies that you have or ever had:_____

_____

Please list all family members with major medical conditions:_____

Are you taking any of the following medications? ○Nerve Pills ○Pain Killers ○Muscle Relaxers ○Insulin

○Stimulants ○Blood Thinners ○Tranquilizers ○Others_____

Do you take: ○Vitamins ○Supplements Do you Exercise? ○Yes ○No If Yes, how much?_____

Are you wearing: ○Heel Lifts ○Sole Lifts ○Orthotics ○Arch Support

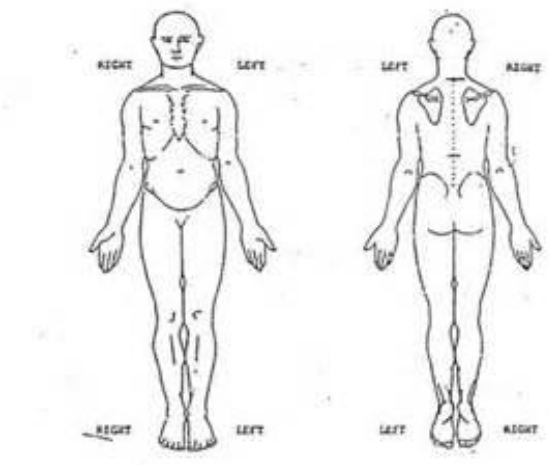
Do you smoke? ○Yes ○No If Yes, how much?_____ How long?_____

For Women: Are you pregnant? ○Yes ○No If Yes, how far along?_____

Are you Nursing? ○Yes ○No Do you take birth control? ○Yes ○No When was your last menses?_____

Do you currently have or ever had any of the following diseases or conditions?

○Yes ○No Heart Attack/Stroke
○Yes ○No Heart Surgery/Pacemaker
○Yes ○No Heart Murmur
○Yes ○No Congenital Heart Defect
○Yes ○No Mitral Valve Prolapse
○Yes ○No Artificial Valves
○Yes ○No Drug/Alcohol Abuse
○Yes ○No Hepatitis
○Yes ○No HIV/AIDS
○Yes ○No Shingles
○Yes ○No Cancer/Chemotherapy
○Yes ○No Emphysema/Glaucoma
○Yes ○No Anemia
○Yes ○No High/Low Blood Pressure
○Yes ○No Psychiatric Problems
○Yes ○No Ulcers/Colitis
○Yes ○No Fainting/Seizures/Epilepsy
○Yes ○No Sinus Problems
○Yes ○No Asthma
○Yes ○No Diabetes/Tuberculosis
○Yes ○No Difficulty Breathing
○Yes ○No Arthritis
○Yes ○No Low Back Pain
○Yes ○No Neck Pain
○Yes ○No Migraines/Headaches



Please diagram your problem areas above using the symbols below and rate the intensity of the pain on a scale of 1-10. A 10 represents the worst pain imaginable. Circle all areas of pain do not fit the descriptions below.

B= Burning
S= Stabbing/Sharp
N= Numbness/Tingling
T= Tightness
A= Aching

Devine Chiropractic and Rehab Center

Informed Consent

I understand that my doctor's recommendations are paramount for my optimum health and the improvement of my condition. Failure to follow my doctor's recommendations may hinder or prolong my recovery and increase the number of visits required to correct my problem.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including, but not limited to diagnostic x-rays on me (or the patient named below, for whom I am legally responsible) by any licensed doctor of chiropractic who treats me at Devine Chiropractic and Rehab Center, P.S.

I have had the opportunity to discuss with my doctor at Devine Chiropractic and Rehab Center, P.S. and/or other office personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all of the risks and complications of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

To Be Completed by Patient

Patient Name:_____

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Signature:_____

Date Signed: ____/____/_____

Witness to Patient's Signature:_____

If Patient is a Minor, Physically, or Legally Incapacitated to be completed by Patient's Representative

Patient's Name:_____

Name of Representative:_____

Date Signed:____/____/_____

Signature of Representative:_____

Relationship of Authority of Patient's Representative:_____

1205 2nd Ave, Suite 120 Seattle, WA 98101 • Tel: (206) 623-2225 • Fax: (206) 467-6337
DowntownSeattleChiropractic.com

Devine Chiropractic and Rehab Center

New Patient Promise

Our promise is based on the simple truth that if we satisfy and care for our patients, they will get well faster and be more likely to share their chiropractic experience with others.

Since chiropractic results vary, we can't guarantee results, but we can promise your satisfaction. So, within seven days of beginning care, if you are not completely satisfied with your decision to begin chiropractic care, we will gladly refund the money you have paid us. Since most spinal problems involve muscles and soft tissue that are slow to heal, continued chiropractic care is often required for maximum improvement.

Office Policies

A clear definition of our policy allows us to concentrate on restoring and maintaining your health. We are always happy to answer any questions that you may have regarding our policy, your account, or your insurance coverage.

Insurance Information

Health and accident insurance policies are an agreement between the insurance carrier and you. We will gladly prepare any necessary reports and forms to assist you in filing claims with your insurance company. Any amount authorized to be paid directly to Devine Chiropractic and Rehab Center, P.S. will be credited to your account upon receipt.

All services rendered to you are charged directly to you and you are personally responsible for payment. In order to facilitate the correct and rapid processing of your insurance claim, you can do the following: Call your insurance agent to determine exactly what coverage you have. Ask what deductible, if any, applies to your policy; and how much of your claim your insurance company will pay. If you have any questions feel free to ask. Our staff is experienced in insurance claim handling and will be glad to assist in any way they can.

1. If you have been in an auto accident or have been hurt on the job, we suggest that you discuss your coverage with our insurance office. We may have suggestions that will help you in this regard.
2. You will be asked to authorize Devine Chiropractic & Rehab Center, P.S. to furnish information regarding your case directly to your insurance company and to assign all benefits as a result of the claim. This will expedite its handling.

Patient Payment Schedule

Our patients' health needs are paramount. Patients are allowed to receive the care they need and reduce the balance on a monthly schedule rather than paying for visits as they are received. Monthly payments are required on all unpaid balances.

Appointment Policy

Please notify our office if you are unable to keep your scheduled appointment. You will not be charged for missed chiropractic appointments. Should you need to cancel or reschedule a massage appointment, we require at least 24 hours notice. Missed massage appointments without 24 hours notice will be charged unless that time can be filled by another patient.

Referral Policy

If you move from our area, we will be glad to refer you to another chiropractor. We will forward you x-rays and records after you sign a release/transfer.

Discharge Policy

If you terminate your care at Devine Chiropractic & Rehab Center before your doctor feels your condition has stabilized, any fees for professional services will be immediately due and payable, unless prior arrangements have been made.

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Other uses of medical information: We will ask for your written authorization before using or disclosing medical information about you in any other situation not covered by this notice. If you choose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing.

Your rights regarding personal medical information: In most cases you have **the right to look at or get a copy of medical informati**on that we use to make decisions about your care after submitting a written request. We may charge a fee for the cost of copying, mailing, or related supplies. If we deny your request to review or obtain a copy of your medical record, you may then submit a written request for a review of that decision.

- If you think that information in your record is incomplete or incorrect **you have the right to request that we correct the records** by submitting a written request. We would deny the request when the information was not created by us, not part of the information maintained by us, or if the record was accurate. You may appeal in writing, a decision not to amend your record.

- **You have the right to a listing of those instances where we have disclosed medical information about you,** other than for treatment, payment, or health care operations or where you specifically authorize the disclosure. You must submit a written request stating the time period desired for the accounting, which must be less than a six-month period starting after April 14, 2003. The first disclosure list in a 12-month period is free.

- You have a right to a paper copy of this notice.

You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing.

- **You may request in writing that we do not use or disclose your medical information** for treatment, payment, or health care operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency.

We are not legally required to accept your request, but will consider it and inform you of our decision. All written requests or appeals should be submitted to Dr. James A. Devine.

Complaints:
If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact Dr. James A. Devine at 1205 2nd Avenue, Suite 120, Seattle, WA 98101.

- Finally, you may send a written complaint to the U.S. Department of Human Services Office Civil Rights. We will be happy to provide the address.

- Under no circumstances will you be retaliated against or penalized in any way.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed that the amount paid the Doctor , for x-rays, is for the examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Acknowledgement:
By signing my name below, I acknowledge receipt of a copy of this notice, and my understanding and agreement to its terms.

Printed Name_____

Signature_____Date_____

Consent to Treat a Minor_____ Date_____

Guardian Signature Authorizing Care_____ Date_____