PrimeSpine Chiropractic & Massage Therapy

Full Legal Name: _____ Date of Birth:_____

Preferred Name: _____ Gender: _____

Address: (**including City/State/Zip**)_____

Primary Phone Number: _____Occupation:_____

Email Address: _____

Emergency Contact Name and Phone Number: _____

Referred By:: _____

Current Medical Conditions/Complaints: _____

_____

Current Medications (including blood thinners): _____

_____

Major Surgeries/Injuries (past/future) :_____

_____

Health Insurance Name and Member ID*: _____

Co-pay, deductible amount, or cash rate payment is due at the time of service.

Minor Consent (If applicable) I authorize Dr.Baker/Dr. Kelley and/or the massage therapist(s) to administer care, as deemed necessary.

Parent Name: _____Signature: _____

Is this related to a car accident/work injury? __Y/N_ Date of Injury: _____

Insurance Company: _____Claim #: _____

Claim Manager Name, Phone, Email: _____

Attorney:_____

(MVC) Third-Party Insurance Name: _____

Claim Manager Name, Phone, Email: _____

Attorney Name, Phone, Email:_____

**If there is no personal injury protection and/or if the claim is not open/available we require health insurance & payment. 3rd party claims are required to pay at time of service*

I confirm that the information I provided is true and accurate to the best of my knowledge

Signature and Date: _____

Acknowledgment of Receipt of Privacy Practices (HIPAA)

I understand that as part of my health care, Washington Health Associates/PrimeSpine originates/maintains paper and/or electronic records describing my health history and treatment plans. I understand that this information serves as a basis for planning my care and treatment, communication among the health professionals who contribute to my care, information for applying my diagnosis and treatment information to my bill, a means by which a third-party payer can verify that services billed were actually provided, and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals. I understand that I have the following rights and privileges: to review this notice prior to signing, to object to the use of my health information for directory purposes, and to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations. I understand that Washington Health Associates/PrimeSpine is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations. I further understand that Washington Health Associates/PrimeSpine reserves the right to change its notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. I wish to have the following restrictions to the use or disclosure of my health information: I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

Workers Compensation

Washington Health Associates/PrimeSpine will bill your ***open, approved*** claim. Please be advised that in the event your claim is denied you are financially responsible for all charges. If you are receiving treatment at another facility at the same time you are being treated with Washington Health Associates/PrimeSpine, you are responsible for tracking your authorized visits. In the event you exceed your authorized visits as a result of treatment at another facility, you will be financially responsible. If the claim is not open/allowed for billing or the transfer of care has not been approved, your private health insurance does not cover any treatments, any remaining balance will be your responsibility.

Motor Vehicle Collision

Washington Health Associates/PrimeSpine will bill my insurance company on my personal injury protection and/or medical payment coverage, if available. **If coverage is not available (or if you exhaust your benefits)**, we require health insurance and then payment at the time of service. *Patients without PIP and/or exhausted PIP and without medical coverage are required to pay a portion of treatment upfront, the remaining balance that is owed is paid when the patient receives their settlement after the treatment is finished.* We will go over the payment plan details with you if you do not have any coverage.

Insurance Policy

I hereby assign all medical benefits to which I am entitled to Washington Health Associates/PrimeSpine in the event they file insurance on my behalf. I understand that Washington Health Associates/PrimeSpine strongly encourages me to verify my benefits with my insurance company. Should I decide not to check my benefits, I understand that any fees accrued with that insurance company that does not pay will be my responsibility. I understand that I am financially responsible for all charges whether or not processed/paid by insurance. As a courtesy to you, we will verify and get a quote of your benefits then go over your benefit details on your first or second visit. It is the patient's responsibility to track any visit limits through their insurance carrier. **All payments are due at the time of service.**

Massage Policy

We are happy to reschedule your appointments; however, when a conflict occurs our policy requests a 24-Hour notice from the time your appointment is scheduled to cancel. *We have zero tolerance for no-shows* if you fail to attend your scheduled appointment and do not provide us with the appropriate prior notification ***you will be automatically charged a fee of $45.*** This fee is not billable through your insurance and you will not be able to schedule another appointment until this fee is paid. You will be banned from scheduling future appointments and will be able to schedule on a same-day basis only. If you fail to show and/or communicate to our office for two consecutive sessions, we will consider you discharged from our care and we will cancel all scheduled appointments going forward. You will be required to put a card on file to hold future appointments.

I have read and fully understand the above statements, and accept the terms of this consent. All questions regarding the doctor's/massage therapist(s) objectives pertaining to my care in this office have been answered to my complete satisfaction. I, therefore, accept Chiropractic/Massage therapy care on this basis.

Patient/Parent Signature: _____ Date: _____

Health History (Check all that apply)

Musculoskeletal

_ Osteoporosis
_ Arthritis
_ Joint Replacement
_ Dislocations
_ Fractures/Broken Bones
_ Disc Herniation/Rupture
_ Stiffness/Swelling
_ Headaches/Migraines
_ Jaw Pain/TMJ
_ Strains/Sprains
_ Problems Walking
_ Scoliosis
_ Bone/Joint Disease
_ Tendinitis
_ Bursitis
_ Chest, ribs, abdominal pain
_ Back/Hip Pain
_ Neck, Shoulder, Arm Pain
_ Leg/Foot Pain
_ Spasms/Cramps

Medical History

_ Cancer Type:
_____
_ Diabetes Type:
_____
_ High Blood Pressure
_ Low Blood Pressure
_ High Cholesterol
_ History of Falling
_ Stroke or TIA
_ Epilepsy
_ Emphysema
_ Kidney Disease
_ Seizures
_ Pacemaker
_ Numbness/Tingling/
_ Fatigue
_ Chronic Pain
_ Sleep Disorders
_ Sinus Problems
_ Rashes
_ Allergies
_ Athletes Foot
_ Pressure Sores
_ Dizziness
_ Heart Condition
_ Lymphedema
_ Hormone Replacement Surgery

_ Blood Clots
_ Asthma
_ Varicose Veins
_ Deep Vein Thrombosis
_ Crohn's Disease
_ Osteoporosis
_ Ulcers
_ Paralysis
_ Herpes/Shingles
_ Cerebral Palsy
_ Multiple Sclerosis
_ Spinal cord injury
_ Hysterectomy
_ IUD
_ Pelvic Inflammatory Disease
_ Endometriosis
_ Fibromyalgia
_ Hemophilia
_ Colitis
_ Indigestion
_ Constipation
_ Communicable Disease (HIV, Hep C)
_ Drug Use: _____
_____

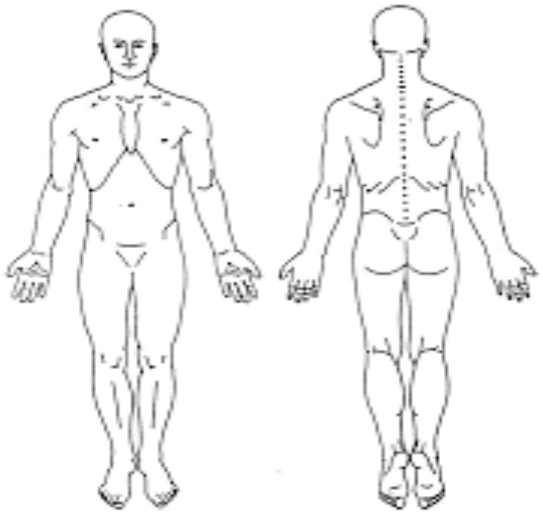
Alcohol Use: _____
_____
Caffeine Use: _____
_____
Allergies (Specify):
_____
_____
_____
Cosmetic Surgery (Specify):
_____
_____
Pregnancy (If current, due date):
_____
How much physical activity do you get in a week?
_____

Changes in Health

_ Decreased Coordination
_ Nausea/Vomiting
_ Appetite Changes
_ Hearing Loss
_ Vision Changes
_ Bowel/Bladder Changes
_ Depression/Mood Changes

List any other health information you would like us to be aware of
_____
_____
_____
_____

- **Please circle areas of discomfort** -



-