ELITE
CHIROPRACTIC & MASSAGE

8131 W. Klamath Ct., Ste H.
Kennewick, WA 99336
Phone: (509) 736-5456
Fax: (509) 735-9868

Confidential Patient Health Record

Today's Date: _____ / _____ / _____

How did you hear about us? _____

Personal Information

Last Name: _____ **First Name:** _____ **Middle Initial:** ____

Preferred Name you wish us to use: _____

Date of Birth: _____ **Sex:** Male / Female **SSN:** _____

Address: _____ **Apt #** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: (_____) _____-_____ **Cell Phone:** (_____) _____-_____

Email: _____

Would you like TEXT reminders? Yes / No : Standard text message rates may apply.

Martial Status: Single Married Widowed Divorced Separated Minor

Emergency Contact: _____ **Ph:** (_____) _____-_____

Race: Caucasian Hispanic Asian African American Decline to answer Other

Preferred Language: English Spanish French Other _____

Employment Information

Employer: _____ **Occupation:** _____

Work Phone: (_____) _____-_____

Health Care Information

Chief Complaints: Neck Pain Lower Back Pain

Upper Back Pain Mid Back Pain Hip Pain

Shoulder/Arm Pain Leg/Knee Pain Headaches

Numbness/Tingling Other: _____

Do you have a family doctor? Yes No

Name of Doctor: _____

Are you pregnant? No Yes Weeks: _____

Number of children: _____ **Right / Left Handed**

Height: _____ **Weight:** _____

Prior Surgeries: _____

_____

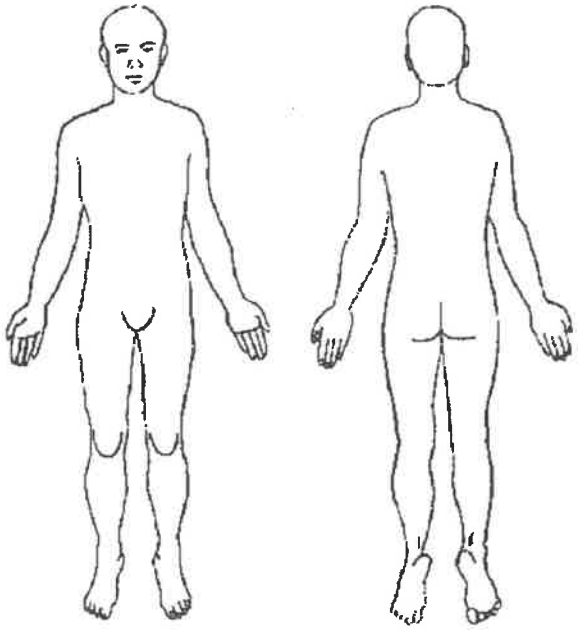
Other health problems the doctor should be aware of?

_____

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

Key: A= Ache B= Burning N= Numbness

P= Pins & Needles S= Stabbing



Please circle the number that best describes your level of pain

1 2 3 4 5 6 7 8 9 10

Mild Moderate Severe

Were your symptoms due to a specific incident, If so, explain _____

_____

If not from specific incident, current symptoms are:

____ Gradual ___ Chronic ___ Had for years off and on _____ Unknown how began

Family History of Illness: _____

Current Medications: _____

Nutritional Supplements: _____

Any Drug Allergies: _____

Social History

Alcohol: Never Socially Occasionally Drinks per day: _____

Tobacco: Never Former Smoker Occasional Smoker Everyday Smoker

Exercise: No Yes Hours per week: _____

Would you be interested in Massage? ____ YES ___ NO

Patient Signature: _____ **Date:** _____

General/Financial Policy

Welcome to Elite Chiropractic and Massage! We strive to provide you with excellent care in a clean, friendly, professional setting and our goal is to make your visits as convenient as possible.

By signing below, you confirm that you have read this policy and understand that:

- It is your responsibility to inform our office of any address or telephone number changes.
- Your account is to be kept current. All self pay or insurance copayments, co-insurances and deductibles will be collected at the time of service payable by cash, check, Visa or MasterCard.
- If you do not have your payment (s), your appointment may be rescheduled.
- If you are unable to keep a scheduled massage appointment, please notify us no later than 24-hours before so that we may offer that time to another patient. **There will be a charge for cancellations without proper notification. This charge is not covered by any insurance companies including auto or work injuries.**
- A returned check will result in a $25 service charge.

IF YOU HAVE HEALTH INSURANCE COVERAGE: As a courtesy to you, our office will attempt to pre-verify your insurance coverage for Chiropractic and Massage care. Coverage information is obtained from your insurance company using information provided by you prior to your initial visit. Please be advised that the information provided by your insurance company is not a guarantee of payment, only an estimate of what might be covered under your policy at the time of service.

By signing below you confirm you understand that:

- It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified.
- Not all services are a covered benefit with all insurance plans.
- You are responsible for any non-covered charges not payable by your insurance company.
- Final determination of benefits available is determined when the claim is sent to your insurance company and we receive an explanation of benefits from them.
- After all co-pays, contracted plan reductions and insurance payment credits are applied to your account, any remaining portion will be your responsibility.
- **MEDICARE PATIENTS:** please be advised that Medicare **only covers** Spinal Adjustments in a Chiropractor's office. As a result Medicare New Patient Exams are reduced and is your responsibility.

By signing below, you have read and understand the above policies and agree to meet all financial obligations. The patient also understands and agrees to allow this office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

Signature of Patient/Legal Guardian _____ Date _____

CONSENT TO RELEASE INFORMATION: In the event that you ever wish to have a family member or friend come to our office and get a copy of your medical records for whatever reason, we ask that you sign below allowing them to do so. By signing below I hereby give my consent for Elite Chiropractic and Massage to release my medical records to:

Name of Friend or Family Member _____ Signature of Patient/Legal Guardian _____ Date _____

CONSENT TO TREAT: I consent to chiropractic and massage treatment having been informed of treatment procedure, alternative forms of care and risk of treatment, namely injuries (sprain/strains, broken bones, stroke, etc.) which, although extremely rare, may occur during a chiropractic or massage care.

Printed Name _____ Signature of Patient/Legal Guardian _____ Date _____