PATIENT HISTORY CONSULT

Date:_____

TELL US ABOUT YOU:

Name: _____ Birth Date: _____ Age:_____ ☐ Male ☐Female
Address:_____ City: _____ State: _____ Zip: _____
E-mail Address: _____ Phone#: Cell/Home _____
Marital Status:☐ Single ☐Married ☐Widowed ☐Divorced Social Security #:_____
Employer: _____ Occupation: _____
Spouse's Name _____ Number of children & Ages:_____
Name & Number of Emergency Contact: _____ Relationship:_____
How were you referred to our office? _____

TELL US ABOUT YOUR PAIN:

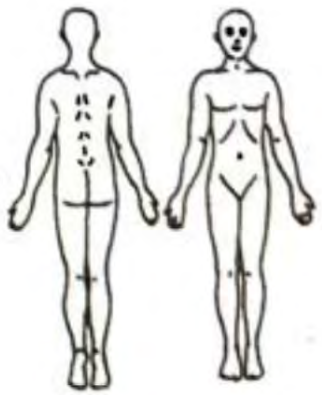
1. Primary Symptom: _____
2. Secondary Symptom:_____
3. Third Symptom:_____
4. Fourth Symptom: _____

On a scale of 1 to 10, (10 being the worst pain and zero being no pain) circle a range that conveys your pain intensity

Primary Pain:	No Pain 0 - 1- 2 - 3 - 4 - 5- 6- 7- 8 - 9 - 10	So Bad you are going to the E.R.
Second symptom:	0 - 1- 2 - 3 - 4 - 5- 6- 7- 8 - 9 - 10	
Third symptom:	0 - 1- 2 - 3 - 4 - 5- 6- 7- 8 - 9 - 10	
Fourth symptom:	0 - 1- 2 - 3 - 4 - 5- 6- 7- 8 - 9 - 10	

*PLEASE MARK the areas on the Diagram with the following letters to describe your symptoms:
R = Radiating B = Burning D = Dull A = Aching N = Numbness S = Sharp/ Stabbing T= Tingling

NOTES:_____
_____
_____
_____
_____
_____
_____



Have you been treated by another facility for these symptoms?☐No ☐Yes
If yes, Where & When? _____
What did they do for you?☐Exam ☐X-Ray ☐MRI ☐CAT ☐Medication ☐PT_____
Did it resolve your pain? ☐Yes ☐No,Outcome:, _____
Have you seen a Chiropractor before? ☐No ☐Yes; Name: _____

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QUALITY OF LIFE:

How is the pain affecting your life? ☐Social ☐Work ☐Normal Activities of Daily Living ☐Hobbies ☐Recreational Intimacy ☐Exercise

NOTES:_____

_____

_____

_____

PAST HISTORY:

Do you have any pre-existing conditions we should be aware of? ☐YES ☐NO

☐Broken Bones ☐Disability ☐Diabetes ☐Stroke ☐Thyroid Issues
☐Tumors ☐Cancer ☐Spinal Surgery ☐High Blood Pressure
☐Rheumatoid Arthritis ☐Heart Attack ☐OTHER: _____

PREVIOUS INJURIES: ☐NO ☐YES; _____
SURGERIES: _____
CHILDHOOD DISEASES: ☐Chicken Pox ☐Measles ☐Mumps ☐OTHER: _____
CONDITIONS Diagnosed as an ADULT: _____
Are there any hereditary conditions the doctor should be aware of? ☐No ☐Yes:_____

SOCIAL HISTORY:

1. **Smoking:** ☐Cigarettes ☐Vape ☐Cannabis ☐Cigar ☐Pipe ☐Chew
   ☐Daily Weekends Occasionally Never

2. **Alcoholic Beverage:** ☐Daily ☐Weekends ☐Occasionally ☐Never
3. **Recreational Drug use:** ☐Daily ☐Weekends ☐Occasionally ☐Never

AUTHORIZATION TO TREAT:

I hereby give my consent for examination/treatment and where applicable, authorize payment to be made directly to Momentum Chiropractic for all benefits which may be payable under my policy or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Momentum Chiropractic for any and all services I receive at this office.

_____ _____
Patient or Authorized Person's Signature Date Completed

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MEDICATION LOG

Medication	Dosage	Frequency	Condition	Prescribing MD

Patient Name:_____ **Date:**_____

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628 3nl Street SE.
Puyallup, WA 98372
(253) 845-6636

PRIVATE INSURANCE FINANCIAL POLICY

We appreciate your decision to consult us for your chiropractic health needs, and we will do all we can to provide you with the very best of care. In return, we ask that you carefully review the portion(s) of this policy statement that pertain to you and sign below. If you have any questions with this policy, we will be happy to discuss them with you.

BASIC POLICY: Payment in full is required at the time services are rendered.

PRIVATE INSURANCE: As a courtesy to our patients, our office accepts "Assignment of Benefits" (payment by the insurance company made directly to this office). Until your deductible is met, payment is expected as per the BASIC POLICY. Any amount not paid by your insurance company within 60 days will become a cash balance as per the BASIC POLICY, and will be subject to monthly service billing charge. Please note that your insurance is an agreement between .you and your insurance company. It is important that you clearly understand and agree that you are personally responsible for all services rendered to you in our office, regardless of what your insurance covers.

1. Our fees generally fall in the range of what is accepted by most insurance carriers. This range applies only to companies that pay (such as 50% or 80%) percentage of U.C.R. is defined as usual, customary, and reasonable rates for this region or community. This statement may not apply with companies that pay based on arbitrary "schedule" of fees. Such fees bear no relationship to the current standard of fees for this region or community.

2. For exams and x-rays, we require a payment of $50 at the time of service. If your insurance company pays more than expected, we will apply the credit to your account. Please note this rarely occurs.

We endeavor to provide all courtesy regarding insurance billing but want to emphasize that our relationship is with you and not your insurance company. All charges incurred will be the responsibility of the patient. We realize that temporary financial problems may arise and invite you to contact us immediately to make arrangements to manage your account.

If you have any questions about the above information or questions regarding insurance
Please feel free to contact us. We are here to help!

I _____ have read, understand and agree to the above policy.

Signature _____ Date _____

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HIPAA Notice of Privacy Practices

Advance Health Chiropractic
DBA: Momentum Chiropractic
628 3rd St Se
Puyallup, WA 98372
(253) 845-6636

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

I. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose our protected health information as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to i nvestigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health Information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health Information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

State Mandated Exemptions

- We are required by Washington State Law to disclose health information to the Department of Labor and Industries or a self-insured employer for workers' compensation or crime victims' claims.
- We can disclose health information to an employer about light duty work without a patient authorization.
- We can disclose health information to an employer without a patient authorization if that information is about a workplace injury or illness, a workplace medical surveillance, or a return-to-work examination.
- Because this disclosures to the department or self-insurer are required by law, patients cannot object to or request that we restrict those disclosures, (45 CFR §§ 164.512,164.522(a)(l)(v)).

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. ***We will not retaliate against you for filing a complaint.***

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature: _____ Date:_____

MEDICAL FORM RELEASE

(HIPPAA Release Form)

PATIENT: _____ Date of Birth:_____

RELEASE OF YOUR INFORMATION:

I authorize the release of information including: appointments, diagnosis, records, examination results, medication log and claim/s information.

This information may be released to:

- ☐ Spouse _____
- ☐ Child{ren} _____
- ☐ Other _____
- ☐ Information is not to be released to anyone.

MESSAGES:

You may call:

- ☐ my home
- ☐ my work
- ☐ my cell

If unable to reach me:

- ☐ you may leave a detailed message
- ☐ leave a message asking me to return your call

The best day & time to reach me is: _____

EMAIL:

You may:

- ☐ use my e-mail address to send general messages/information
- ☐ use my e-mail address to send detailed messages/information

This ***Release of Information*** will remain in effect until terminated by me in writing.

Signed: _____ Date: _____
Office Staff/Witness: _____ Date:_____

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