VOSS CHIROPRACTIC CONFIDENTIAL HEALTH REPORT

Name:_____ Date: _____ Sex: _____
(Last) (First) (Middle)

DOB: _____ Height: _____ Weight:_____ Occupation: _____ Date of onset:_____

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:
O- CIRCLE ALL ITEMS THAT ARE COMMON TO OTHER FAMILY MEMBERS:

- ☐ Aids
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Eczema
- ☐ Epilepsy
- ☐ Foot Problems
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Malaria
- ☐ Measles
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Pollo
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Venereal Disease

Please list any prescription drugs now taking: _____

_____

Past Surgeries: _____

_____

Allergies: _____

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case.
THIS IS A CONFIDENTIAL HEALTH REPORT.

GENERAL

- ☐ Allergy
- ☐ Convulsions
- ☐ Dizziness
- ☐ Fainting
- ☐ Neuralgia
- ☐ Numbness

EYES, EARS, NOSE & THROAT

- ☐ Asthma
- ☐ Colds
- ☐ Deafness
- ☐ Earache
- ☐ Ear discharge
- ☐ Ear noises
- ☐ Eye pain
- ☐ Nasal Obstruction
- ☐ Nose bleeds
- ☐ Sinus infection

CARDIO-VASCULAR

- ☐ Hardening of arteries
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Pain over heart
- ☐ Poor circulation
- ☐ Rapid heartbeat
- ☐ Slow heartbeat
- ☐ Swelling of ankles

GASTRO-INTESTINAL

- ☐ Colon issues
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Distension of abdomen
- ☐ Gallbladder issues
- ☐ Hemorrhoids
- ☐ Liver Issues
- ☐ Pain over stomach

NONE	LIGHT	MODERATE	HEAVY	
☐	☐	☐	☐	Alcohol
☐	☐	☐	☐	Coffee
☐	☐	☐	☐	Drug
☐	☐	☐	☐	Exercise
☐	☐	☐	☐	Soft Drinks
☐	☐	☐	☐	Tobacco

MUSCLE & JOINT

- ☐ Arthritis
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Low back pain
- ☐ Neck pain or stiffness
- ☐ Pain between shoulders
- ☐ Sciatica
- ☐ Swollen joints
- ☐ Pain, Numbness or cramps
- ☐ Shoulders
- ☐ Arms
- ☐ Elbows
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Knees
- ☐ Feet

GENITO-URINARY

- ☐ Bed-wetting
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ In ability to control kidneys
- ☐ Kidney infection or stones
- ☐ Painful urination
- ☐ Prostate Issues
- ☐ Pus in urine

SKIN

- ☐ Bruise easily
- ☐ Dryness
- ☐ Skin eruptions (rash)
- ☐ Varicose veins

RESPIRATORY

- ☐ Chest pain
- ☐ Chronic cough
- ☐ Spitting up blood
- ☐ Spitting up phlegm
- ☐ Wheezing

Signature:_____

Voss Chiropractic Intake Form Motor Vehicle Accident

Today's Date:_____

PATIENT INFORMATION

Name: (Last, First MI) _____ **Birth Date:_____**

Address:_____City/State:_____

Phone Number:_____ Email:_____

Social Security Number:_____

***Referred By:_____**

EMERGENCY CONTACT INFORMATION

Full Name:_____ Phone Number:_____

Relationship: Parent/ Spouse/ Child/ Other: _____

Full Name:_____ Phone Number:_____

Relationship: Parent/ Spouse/ Child/ Other: _____

BILLING INFORMATION:

Date of Accident: _____ Accident Location: _____

Check box that applies:

☐ **Personal Injury Protection (PIP)** ☐ **Third Party Liability (TPL)**

Name of Insured: _____

Insurance Company: _____

Adjuster Name: _____

Phone #:_____

Claim #:_____

ATTORNEY INFORMATION:

Name: _____ Phone: _____

MOTOR VEHICLE ACCIDENT QUESTIONAIRE

Were you: ○ Driver ○ Passenger ○ Back Seat

Were you struck from: ○ Behind ○ Front ○ Left Side ○ Right Side

Were you knocked unconscious? ○ **Yes** ○ **No**

Name: (Last, First) _____

In your own words, describe the accident: _____

_____

Did you have and physical complaints prior to the accident: ○ **Yes** ○ **No** **if yes, please explain:**

_____

In detail, please describe how you felt:

Immediately after: _____

Later that Day: _____

The next Day: _____

What are your present symptoms? _____

Were you taken to the hospital? ○ **Yes** ○ **No** if yes, please explain**:**

_____

Have you seen a doctor since the accident? ○ **Yes** ○ **No** **if yes, please provide name of doctor:**

Name_____ **Phone Number**_____

What type of treatment did you receive? _____

Do you notice any activity restrictions as a result of the injury? ○ **Yes** ○ **No** **if yes, please explain:**

_____

_____

Have you been in an accident before this? ○ **Yes** ○ **No** **if yes, please explain:** Date of accident: _____

_____

_____

Additional Comments:

_____

INFORMED CONSENT TO
CHIROPRACTIC ADJUSTMENTS AND CARE

As in all health care, there are some risks to treatment. I do not expect the doctor to be able to anticipate and explain all risks or complications, however the doctor will do his best to explain the problem. Based on the facts and findings as presented the doctor at the time of treatment, I agree to rely on the doctor to exercise judgment which is based on my best interest and well-being during the course of the procedures.

I have read the above consent with the doctor and/ or staff as indicated by my signature. I have had the opportunity to ask questions about its content. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

For more information, please refer to the following Revised Codes of Washington:

RCW 18.25.005 "Chiropractic" defined

(1) Chiropractic is the practice of health care that deals with the diagnosis or analysis and care or treatment of the vertebral subluxation complex and its effects, articular dysfunction, and musculoskeletal disorders, all for the restoration and maintenance of health and recognizing the recuperative powers of the body.

(3) As part of a chiropractic differential diagnosis, a chiropractor shall perform a physical examination, which may include diagnostic x-rays, to determine the appropriateness of chiropractic care or the need for referral to other health care providers. The chiropractic quality assurance commission shall provide by rule for the type and use of diagnostic and analytical devices and procedures consistent with this chapter.

RCW 18.25.006 Definitions

(5) "Vertebral subluxation complex" means a functional defect or alteration of the biomechanical and physiological dynamics in a joint that may cause neuronal disturbances, with or without displacement detectable by X-ray. The effects of the vertebral subluxation complex may include, but are not limited to, any of the following: Fixation, hypomobility, hypermobility, periarticular muscle spasm, edema, or inflammation.

(9) "Chiropractic adjustment" means chiropractic care of a vertebral subluxation complex, articular dysfunction, or musculoskeletal disorder. Such care includes manual or mechanical adjustment of any vertebral articulation and contiguous articulations beyond the normal passive physiological range of motion.

Patient Signature: _____ Date: _____
(Patient, Guardian, or Authorized Representative)

Personnel Signature: _____ Date: _____

VOSS CHIROPRATIC FEE POLICY
THIRD PARTY LIABILTY FINANCIAL

It is our goal at Voss Chiropractic P.S. to make chiropractic care available to everyone.

- Third party claims are typically those claims when another party is at fault for the auto accident. These insurance companies DO NOT pay for services until the case has been settled and you are considered medically stable by your provider. Our office requires a $100.00 payment at your initial visit and an automatic payment plan agreement (debit/credit) for $100.00 each month thereafter, until your case has been settled and full payment has been received. Medical Liens are part of our billing and collection practices for these claims.

  _____Patient Initial

DISCLOSURE REGARDING USE OF MEDICAL LIENS

- In the event I do not have PIP available for the automobile collision, I authorize Voss Chiropractic, P.S to file a medical lien, for a fee, against any applicable third-party insurance settlement pursuant to RCW 60.44.010, et seq, Pending final resolution of my claim, I understand I will be required to make $100.00 per month payment on any balance owed. I understand and acknowledge that in the event a medical lien is filed, and that if the lien is paid or settled, I will be provided with an original, written Satisfaction of Lien. I further understand that payment of any medical lien, in some circumstances, may not fully pay my outstanding final charges due to Voss Chiropractic, P.S. for treatment provided, and I may be required to make additional payments after satisfaction of the lien.

  _____Patient Initial

Credit Card Authorization Agreement for Automatic Monthly Payments

I _____ authorize Voss Chiropractic to keep my signature on file and to charge the credit card selected below for the following:

Recurring charge of **$100.00** to be charged once monthly every **5th or 20th**
(Circle one)

Card Holders Name: _____

Card Number: _____ Exp. Date: _____ CVC:_____

Cardholder Signature: _____ Date: _____

24 HOUR CANCELLATION & NO SHOW FEE

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, **Voss Chiropractic P.S** reserves the right to charge a **Cancellation/No Show fee** for all missed office visits, rehab visits and massage visits.

No Show fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple “no shows”, may result in termination from our practice.

Thank you for understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

Signature:_____ Print Name:_____

VOSS CHIROPRACTIC FEE POLICY
PERSONAL INJURY PROTECTION

It is our goal at Voss Chiropractic P.S. to make chiropractic care available to everyone.

PIP CLAIMS - Personal Injury Protection policies are available to all automobile policyholders. If you have chosen PIP coverage with your carrier, we will bill them as a courtesy for you for your auto-related injuries.

- I understand that for treatment provided by Voss Chiropractic, P.S., related to an automobile collision, primary first party insurance is with the Personal Injury Protection (PIP) Insurance for the car I was driving, riding in as a passenger, or struck by as a pedestrian/bicyclist. I understand and authorize Voss Chiropractic P.S., to bill PIP and authorize the release of any information acquired in the course of my examinations and treatment in accordance with HIPAA privacy regulations.
  _____ Initial

- I understand in some circumstances, my PIP policy may not fully pay my outstanding final charges due to Voss Chiropractic, P.S. for treatment provided, and I may be required to make additional payments
  _____ Initial

Insurance Information:

Name of Insured: _____

Insurance Company: _____

Adjuster Name: _____

Phone # _____

Claim # _____

Attorney Information:

Name: _____

Phone: _____

My signature below acknowledges I understand the above outlined financial policy.

Patient Signature: _____ Date: _____

24 HOUR CANCELLATION & NO SHOW FEE

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Thank you for understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

Signature: _____

Print Name: _____

HIPAA Disclosure Authorization Form

I _____ hereby authorize **Voss Chiropractic P.S.** to release my medical information and or account information to the following Persons listed below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Full Disclosure: Yes □ No □ Limited Disclosure: Yes □ No □

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, claims processing or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- I have been presented/offered a copy of the County Health Department's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under Federal and State Law.

Signature:_____ Date: _____

Witness By: _____ (Staff Member)