

Patient Name: _____

Date: _____



In Touch With Health Chiropractic Clinic P.C.
 1111 N Northgate Way
 Seattle Washington 98133
 Tel 206.523.2225
 Fax 206.495.9135

Please check any of the following services you are interested in:

- Acupuncture Chiropractic Massage Peripheral Neuropathy Ideal Protein [Weight Loss]

Do you have a Health Savings Account (HSA) yes no

Do you have Flex benefits program yes no

Who can we thank for your referral? _____

Address _____ City _____ State _____ Zip Code _____

H. Phone _____ W. Phone _____ Cell Phone _____

Email Address: _____

Cell Phone Provider (for text reminders) AT&T Verizon T-Mobile Other _____

Preferred communication for patient reminders (circle) Email / Text

Sex: M F Marital Status: M S D W Date of Birth _____

Social Security # _____

Occupation _____

Employer _____

Have you ever received Chiropractic/Massage/Acupuncture Care?

Chiropractic: Yes No If Yes, When? _____

Massage: Yes No If Yes, When? _____

Acupuncture: Yes No If Yes, When? _____

Name of most recent Chiropractor: _____

Name of most recent Massage Therapist: _____

Name of most recent Acupuncture: _____

Patient Name: _____

Date: _____

1. Primary complaint:

2. Secondary complaint:

3. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):

Please circle: Medical Doctor Physical Therapy Massage Therapy Acupuncture
Other: _____

4. Past Health History:

A. Please indicate if you have a history of any of the following:

- Anticoagulant use Heart problems/high blood pressure/chest pain Bleeding problems
- Lung problems/shortness of breath Cancer Diabetes Psychiatric disorders
- Bipolar disorder Major depression Schizophrenia Stroke/TIA's
- Other _____ None of the above

B. Previous Injury, Trauma, Broken bones:

C. Allergies/Medication Allergies:

No Allergies

D. Medications/Supplements:

Medication/Supplement	Reason for taking
_____	_____
_____	_____
_____	_____
_____	_____

I have a medication list attached.

Patient Name: _____

Date: _____

E. Surgeries:

Date

Type of Surgery

F. Pregnancies and outcomes (if applicable):

Pregnancies/Date of Delivery

Outcome

5. Family Health History:

Do you have a family history of? (Please indicate all that apply)

- Cancer Strokes/TIA's Headaches Cardiac disease Neurological diseases
- Adopted/Unknown Cardiac disease below age 40 Psychiatric disease
- Diabetes Other _____ None of the above

Deaths in immediate family:

Cause of parents or siblings death

Age at death

Social and Occupational History:

A. Job description:

B. Work schedule:

C. Recreational activities:

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):

E. Smoking Status (circle one) Every day smoker / Occasional Smoker / Former Smoker / Never Smoked

Patient Name: _____

Date: _____

REVIEW OF SYSTEMS

Have you had any of the following pulmonary (lung-related) issues?

- Asthma/difficulty breathing COPD Emphysema Other _____ None of the above

Have you had any of the following cardiovascular (heart-related) issues or procedures?

- Heart surgeries Congestive heart failure Murmurs or valvular disease Heart attacks/MIs Heart disease/problems Hypertension Pacemaker Angina/chest pain Irregular heartbeat Other _____ None of the above

Have you had any of the following neurological (nerve-related) issues?

- Visual changes/loss of vision One-sided weakness of face or body History of seizures One-sided decreased feeling in the face or body Headaches Memory loss Tremors Vertigo Loss of sense of smell Strokes/TIAs Other _____ None of the above

Have you had any of the following endocrine (glandular/hormonal) related issues or procedures?

- Thyroid disease Hormone replacement therapy Injectable steroid replacements Diabetes Other _____ None of the above

Have you had any of the following renal (kidney-related) issues or procedures?

- Renal calculi/stones Hematuria (blood in the urine) Incontinence (can't control) Bladder Infections Difficulty urinating Kidney disease Dialysis Other _____ None of the above

Have you had any of the following gastroenterological (stomach-related) issues?

- Nausea Difficulty swallowing Ulcerative disease Frequent abdominal pain Hiatal hernia Constipation Pancreatic disease Irritable bowel/colitis Hepatitis or liver disease Bloody or black tarry stools Vomiting blood Bowel incontinence Gastroesophageal reflux/heartburn Other _____ None of the above

Have you had any of the following hematological (blood-related) issues?

- Anemia Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) HIV positive Abnormal bleeding/bruising Sickle-cell anemia Enlarged lymph nodes Hemophilia Hypercoagulation or deep venous thrombosis/history of blood clots Anticoagulant therapy Regular aspirin use Other _____ None of the above

Have you had any of the following dermatological (skin-related) issues?

- Significant burns Significant rashes Skin grafts Psoriatic disorders Other _____ None of the above

Have you had any of the following musculoskeletal (bone/muscle-related) issues?

- Rheumatoid arthritis Gout Osteoarthritis Broken bones Spinal fracture Spinal surgery Joint surgery Arthritis (unknown type) Scoliosis Metal implants Other _____ None of the above

Have you had any of the following psychological issues?

- Psychiatric diagnosis Depression Suicidal ideations Bipolar disorder Homicidal ideations Schizophrenia Psychiatric hospitalizations Other _____ None of the above

Is there anything else in your past medical history that you feel is important to your care here?

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to In Touch with Health Chiropractic Clinic for services performed.

Patient or Guardian Signature _____

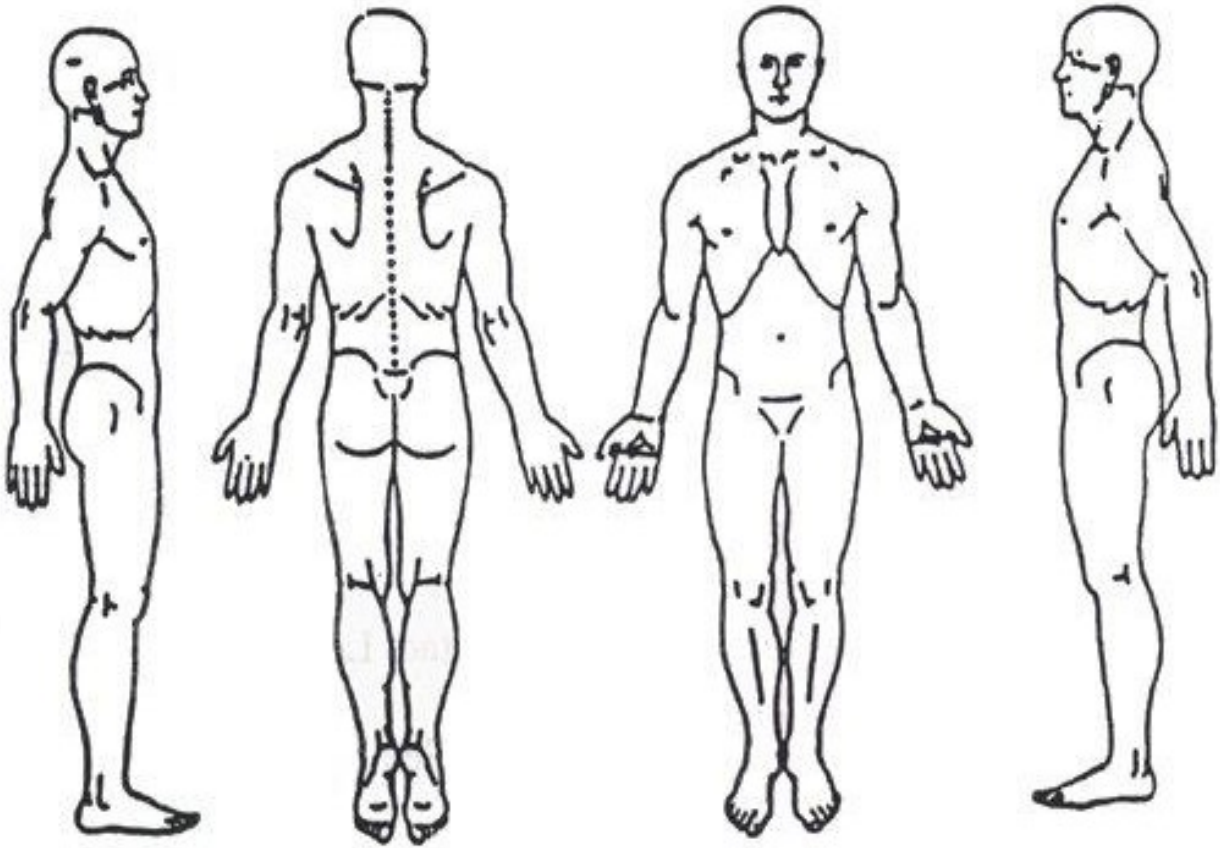
Date _____

Patient Name: _____

Date: _____

Indicate the location of pain/discomfort on the illustration. Use the symbol that best describes the feeling:

XX Sharp/Stabbing **PP** Pins/Needles **DD** Dull/Aching **NN** Numbness



Patient Name: _____

Date: _____

NEW PATIENT HISTORY FORM

Please start at the top of your body and work your way down.

Symptom 1 : _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
 - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
 - Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
 - Morning Afternoon Evening Night Unaffected by time of day

Patient Name: _____

Date: _____

Symptom 2: _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
 - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
 - Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
 - Morning Afternoon Evening Night Unaffected by time of day

Patient Name: _____

Date: _____

Symptom 3: _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
 - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
 - Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
 - Morning Afternoon Evening Night Unaffected by time of day

Patient Name: _____

Date: _____

Symptom 4: _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
 - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
 - Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
 - Morning Afternoon Evening Night Unaffected by time of day

Patient Name: _____

Date: _____

Symptom 5 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
 - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
 - Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
 - Morning Afternoon Evening Night Unaffected by time of day

Patient Name: _____

Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

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 describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our 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, pay your health care bills, to support the operations 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 health care 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 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, marketing, and fund raising activities, and conduction 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 your 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 included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate 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.

Signature of Patient or Representative

Date

Patient Name: _____

Date: _____

Printed Name

CONSENT TO TREATMENT [Chiropractic]

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment. There are some risks that may be associated with treatment, in particular you should note:

- 1) While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment;
- 2) There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.
- 3) There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote;

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms.

Musculoskeletal care contributes to your overall well-being. The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed the following with my healthcare provider:

- a. The condition that the treatment is to address;
- b. The nature of the treatment;
- c. The risks and benefits of that treatment; and
- d. Any alternatives to that treatment.

I have had the opportunity to ask questions and receive answers regarding the treatment.

I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all my present and future care with **In Touch with Health Chiropractic.**

Patient signature (or Legal Guardian)

Signature of Witness:

Print Name: _____

Print Name: _____

Date: _____

Date: _____

Patient Name: _____

Date: _____

Consent To Treat [Acupuncture]

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tiu-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally or in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature:

Date:

(Or Patient Representative) (Indicate relationship if signing for patient)

Patient Name: _____

Date: _____

Financial Policy

We, the staff of In Touch With Health, thank you for choosing us as your health provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest quality care and building a successful provider-patient relationship with you and your family. We believe your understanding of our patients’ financial responsibility is vital to that provider-patient relationship and our goal is to not only inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies, or responsibilities; please feel free to contact **Tien Britton** at (206) 523-2225

We believe this level of communication and cooperation will allow us to continue to provide quality service to all of our valued patients.

Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance, or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service unless a payment arrangement has been approved in advance by our staff. Patients will be held responsible for non-payment by their insurance company. Accounts unpaid by the insurance company greater than 90 days will be billed to the patient.

Choice of payment options: We are happy to provide the following payment options. If you are choosing to use your insurance you will need to pick a second payment option for any service not covered by your insurance.

1. Insurance Coverage: Coverage varies with individual plans; generally only a portion of the recommended care plan will be covered.
2. Cash/Credit per visit: Includes money orders, personal checks, credit and debit cards; generally a 20% discount applies.
3. Payment Plans: Monthly or yearly payment plans are available with an approximate savings of 25-30%.
4. Care Credit Card: A zero-or-low interest healthcare credit card which you may apply for and use here in our office upon request.

Please circle your TWO choices above and initial here: _____

(Initial)

Payments and Returned Checks

We accept payments for your convenience such as (cash, money order, MasterCard, Visa and in-state checks). A \$45.00 service fee will be charged for all returned checks. Additionally, you may authorize us to keep your credit card on file for your convenience knowing that we adhere to the highest level of information security.

We realize that temporary financial problems may affect timely payment of your account. If this should occur please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business.. Outstanding balances greater than 120 days will be turned over to a collection agency unless prior arrangements have been made in writing.

Insurance

Please remember that your insurance is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from the insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims.

Patient Name: _____

Date: _____

It is your responsibility to provide all necessary insurance eligibility, identification, authorization, and referral information and to notify our office of any information changes when they occur. Even a pre-authorization of services does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information. It is the patient’s responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect co-payments, co-insurance, and deductibles, as outlined by your insurance carrier. Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of-network fees. If we are not contracted with your carrier, we will not negotiate reduced fees with your carrier.

Miscellaneous Forms, Additional Information and Authorizations

We will provide all necessary information to have your benefits released. However if it becomes necessary to submit redundant or unnecessary information for the completion of the claim forms for school, sports, or extracurricular activities; there will be an administrative fee, not to exceed \$35.00, for the additional information.

Interest

Simple interest of 1% monthly will incur if a balance remains unpaid after 30 days of receipt of statement.

Missed Massage Appointments

We require notice of cancellations 24 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointments without notifying us in advance: a missed appointment fee will apply. These fees are **\$45.00**. This fee must be paid before any additional massage appointments can be scheduled. Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients.

Medical Records Fees

Patients are entitled under federal law to have access to their protected health information and we follow all rules, guidelines and exceptions to ensure compliance to patient rights. However, providers also have the right to be compensated for records and our fees are a reasonable cost-based fee for copies including the copying, supplies, labor, and postage of the files and or summaries.

We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business.

I have read and understand the above financial policy. I agree to assign insurance benefits to **In Touch With Health Chiropractic** whenever applicable. I also agree, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary.

Signature of Insured or Authorized Representative: _____

Date: _____

Patient Name: _____

Date: _____

Massage Therapy CONTRA-INDICATIONS:

*** Note the following conditions could be aggravated by receiving massage. If you have one of the following conditions, please discuss it with your doctor prior to receiving massage therapy. Thank you.**

1. If you are coming down with a cold/flu (any type of fever or infection)
2. Spinal fracture or broken bones
3. Any cancer (must be cancer- free for 5 years or have M.D. ok)
4. Under the influence of strong pain medication
5. High blood pressure (if not under control or M.D. supervision)
6. Acute or current inflammation such as rheumatoid arthritis or gout
7. Acute or current blood clot
8. Pregnant (should be approved by M.D.)

*Please ask your doctor if your condition is safe for massage
I understand these contradictions and approve treatment.

Patient Signature: _____ **Date:** _____

Patient Name: _____

Date: _____

Billing Information

Please fill out the following information if you would like us to bill your insurance company

Name of Insurance Company: _____

Phone Number of Insurance Company: _____

Name of Insured: _____

Name of Patient: _____

Group No.: _____

Policy No.: _____

Billing Address: _____

This is my (please check the one that applies):

_____only insurance _____**primary** insurance _____**secondary** insurance

____Auto Insurance (Motor Vehicle Collision)____Workers Compensation(Injury on the job)

We also need to make a copy of your insurance card.

By signing below, I acknowledge that I understand that it is my responsibility to know what my coverage benefits are through my insurance company and that it is recommended that I call my insurance company to understand the coverage they offer through my insurance plan. I understand that any benefit information that is given to me by staff at In Touch with Health may be incorrect or may change at any time according to my insurance company’s discretion.

I acknowledge that I understand that my insurance company may **deny payment** if they determine that a particular service that is rendered at this office, although it would otherwise be covered, is not reasonable and necessary under their standards. I am also aware that if my insurance company denies payment, I am fully responsible for those charges.

Signature: _____ Date: _____

Patient Name: _____

Date: _____

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name: _____

Last Name: _____

Email address: _____ @ _____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ Gender (Circle one): Male / Female Preferred Language: _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

Family Medical History <i>(Record one diagnosis in your family history and the affected)</i>				
Diagnosis (Write in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)
<i>Example: Heart Disease</i>		X		

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? <i>(Include regularly used over the counter medications)</i>	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

I choose to decline receipt of my clinical summary after every visit *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____

Date: _____

For office use only	
Height: _____	Weight: _____ Blood Pressure: _____/_____/_____