HALEY CHIROPRACTIC CLINIC

1919 NO. PEARL ST. #A4

TACOMA, WA 98406

CONFIDENTIAL PATIENT HISTORY **DATE**_____

Name_____Phone_____Cell #_____

Address_____City_____State _____ Zip_____

SS#_____ Date of Birth _____ Marital Status: S M W D

Employer_____Address_____

_____Work Phone _____Ext._____

Email Address: _____

Have you received chiropractic care in the past? ☐ Yes ☐ No

Are you currently under chiropractic care? ☐ Yes ☐ No

The reason for this visit: ☐ PI (automobile accident) ☐ L&I (injury on the job) ☐ Other_____

How did you hear about our office? ☐ Website ☐ Phonebook ☐ Other _____

INSURANCE COVERAGE

We can bill your insurance as a courtesy to you. Will we be billing insurance for you? ☐ **Yes** ☐ **No**

☐ Private Insurance ☐ Medicare Coverage (also provide your supplemental insurance info)

Name of Insurance_____Address_____

Phone_____Policy Number_____Group #_____

Policy Holders Name_____Employer_____

SS# of policy holder_____ Date of birth _____

HEALTH INFORMATION

Chief Complaint:_____

List all symptoms: _____

When and how did this start: _____

Have you ever had similar symptoms? If yes, when ? _____

☐ Is it getting better? ☐ Worse? ☐ Unchanged?

List any other Doctors or Therapists you have seen for this condition:

1._____ 3. _____

2._____ 4. _____

What were you told _____

_____

What type of treatment did you receive _____

Remarks:_____

_____

List previous accidents or injuries (auto, work, falls, etc.)

1. _____ 3. _____

2. _____ 4. _____

List and previous surgeries and year_____

List any previous illnesses: _____

List medication you are currently taking or have taken in the last six months: _____

_____

List any self-medications, i.e. vitamins, minerals, herbs, remedies, etc. : _____

_____

Do you smoke?_____ . If yes, how many packs per day? _____.

Use alcohol? _____. If yes, list oz. per day _____

Use of laxatives, aspirin or other preparations constantly? ☐ Yes ☐ No

If yes, please give dosage amount of each

_____

_____.

FAMILY MEDICAL HISTORY: (i.e. parents, siblings)

_____

Is there anything else that is causing you considerable concern, worry or stress?_____

_____.

SYMPTOMS REVIEW

In the section below list any problem you now have, or have had. (For example: Head conditions might include headache, migraines, fainting, dizziness, etc) If there is a problem that you are aware of please list it. If no problem exists please **N/A** after that system.

Head_____

Ear, eyes, nose, throat: _____

Lungs/respiratory: _____

Heart/circulation

_____

Stomach/intestine/colon: _____

Kidney/bladder/urinary: _____

Liver/gallbladder/pancreas/spleen: _____

Skin/hair/nails: _____

Hematological/bleeding/anemia: _____

Bone or muscle other than already described: _____

Nerve or nervous involvement other than already described: _____

Endocrine system, i.e., thyroid, adrenal, pituitary, etc. : _____

Central nervous system, i.e., stroke, epilepsy, etc. : _____

Lymph glands, i.e., swelling, painful, etc. : _____

Allergies: _____

HALEY CHIROPRACTIC CLINIC
CIRCLE "C" IF THE CONDITION IS CURRENT OR
"F" IF THE CONDITION IS FORMER

FOR WOMEN ONLY

C / F PREGNANT
C / F PAINFUL MENSTRUAL CYCLE
C / F MISCARRIAGE
C / F HOT FLASHES
C / F MENOPAUSAL SYMPTOMS
C / F CONGESTED BREAST
C / F LUMPS IN BREAST

FOR MEN ONLY

C / F DIFFICULTY IN URINATION
C / F DRIBBLING BLADDER
C / F DISCHARGE
C / F DEEP PAIN ON URINATION
C / F IMPOTENCE
C / F PAIN IN TESTICLES

FOR CHILDREN ONLY

C / F BED WETTING
C / F POOR REST AT NIGHT
C / F STOMACH PAIN
C / F IRRITABLE
C / F ALLERGIES:_____
C / F INABILITY TO CONTROL BOWELS
C / F FREQUENT COLDS
C / F HYPERACTIVE

FOR EVERYONE

C / F PERSONALITY CHANGES
C / F IRRITABILITY
C / F INSOMNIA
C / F HIGH BLOOD PRESSURE
C / F SKIN DISORDER
C / F TREMORS
C / F ARTHRITIS
C / F SHINGLES (HERPES)
C / F BODY BENT TO SIDE (ANTALGIC)

HEAD/NECK

C / F SINUS DISORDER
C / F HEADACHES/MIGRAINES
C / F LIGHT SENSITIVITY
C / F DIZZINESS/VERTIGO
C / F EARACHE
C / F THROAT CONDITION
C / F FACIAL PAIN
C / F HEAD/NECK TENSION
C / F RESTRICTED NECK MOVEMENT

BACK

C / F POOR POSTURE
C / F UPPER BACK PAIN
C / F BURSITIS/SYNOVITIS
C / F BURNING SENSATION – UPPER BACK
C / F ARTHRITIS UPPER BACK/SHOULDERS
C / F LIMITED MOTION – UPPER BACK
C / F MID/LOW BACK PAIN
C / F BURNING ACROSS MID/LOW BACK
C / F SCOLIOSIS
C / F KYPHOSIS (BENT BACK)
C / F PAIN WHEN BENDING IN MID/LOW BACK
C / F NUMBNESS/TINGLING MID/LOW BACK
C / F MID/LOW BACK SHOOTING PAINS
C / F MID/LOW BACK PAIN FROM SITTING
C / F MID/LOW BACK PAIN FROM LYING DOWN
C / F MID/LOW BACK PAIN ON STRAINING
C / F MID/LOW BACK PAIN ON PUSH/PULL
C / F MID/LOW BACK SPASMS
C / F TAIL BONE PAIN
C / F PAIN/SPASM WHEN GETTING UP

CHEST/ABDOMINAL

C / F HERNIA
C / F PAIN ACROSS KIDNEYS
C / F PAINFUL STERNUM
C / F PAIN/TENSION ACROSS CHEST
C / F WEAK BLADDER
C / F FLOATING RIB
C / F UNEXPLAINED ABDOMINAL PAIN
C / F RESTRICTED TORSO MOVEMENT
C / F HIATAL HERNIA
C / F DIFFICULTY BREATHING

SHOULDER/ARMS/LEGS/FEET

C / F PAIN OVER SCAPULA R L
C / F SHOULDER/NECK SPASMS
C / F SHOULDER PAIN
C / F LIMITED ARM MOVEMENT R L
C / F ARM/ELBOW PAIN
C / F NUMBNESS/TINGLING – ARMS/HANDS
C / F POOR CIRCULATION – ARMS/HANDS
C / F JOINT STIFFNESS/PAIN
C / F TENNIS ELBOW
C / F PAIN WHEN RAISING ARMS
C / F HIP PAIN
C / F PAIN DOWN OF LEGS
C / F SWOLLEN/KNEES ANKLES
C / F NUMBNESS/TINGLING OF LEGS/FEET
C / F GROIN PAIN

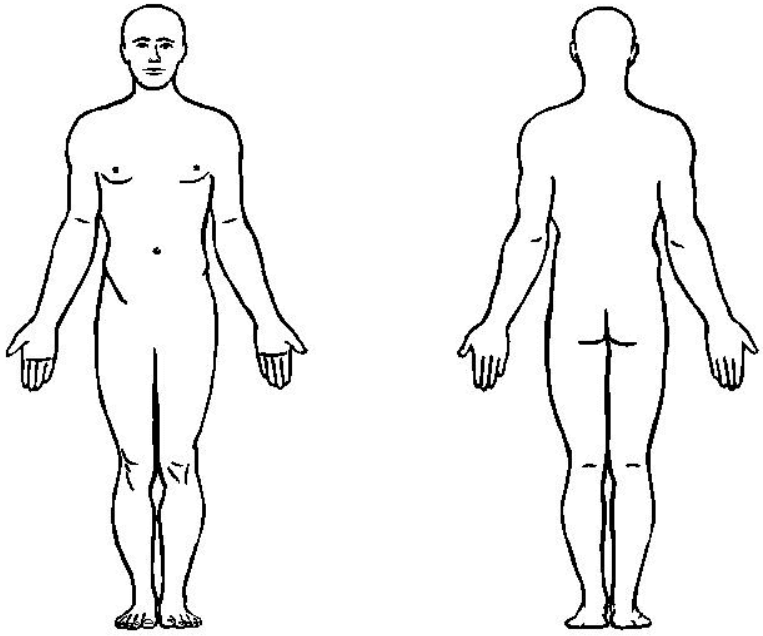
PATIENT'S NAME_____DATE SIGNED_____

PATIENT'S SIGNATURE_____
(If minor, parent or guardian)

HALEY CHIROPRACTIC CLINIC
1919 N Pearl. St., #A-4
Tacoma, WA 98406
(253) 761-0930

Name_____Date_____

Indicate on the drawing what symptoms you are experiencing with:
B-Burning
S-Stabbing
A-Aching
P-Pins & Needles Sensation
X-Pain



Describe your job duties_____

_____

_____

Circle all that apply to your job duties:

Sitting standing desk counter work bench lifting bending stooping twisting carrying walking arms overhead Other_____

Physical work strains (circle one) Light Moderate Heavy Strenuous

Exercise/Sports:_____

Your Height _____**Your Weight**_____

HALEY CHIROPRACTIC CLINIC PAYMENT POLICY

Dear Patients,
As of January 1, 2017, our office is enforcing the pay at time of service policy. You will be responsible for your payment i.e. copays, and cash patient portions at the time of service.

PATIENTS WITHOUT INSURANCE COVERAGE FOR CHIROPRACTIC CARE are expected to pay for services in full at the time services are rendered. If payment arrangements need to be made, please consult with the billing manager before making an appointment. A billing fee may be applied to your account if your estimated portion due is not received at the time of service. You will also be charged to full billing rate instead of the PATOS rate.

CURRENT PAY AT TIME OF SERVICE (PATOS) RATES
$45 PER ADJUSTMENT (REGIONS 1-2 OR 3-4)
$15 FOR TRACTION (OPTIONAL TREATMENT DECIDED BY YOUR DOCTOR)

CURRENT BILLING RATES
$50 FOR 1-2 REGION
$60 FOR 3-4 REGION
$25 FOR TRACTION (OPTIONAL TREATMENT DECIDED BY YOUR DOCTOR)

PATIENTS WITH INSURANCE COVERAGE FOR CHIROPRACTIC CARE: If your private insurance policy provides chiropractic benefits we will be happy to submit a claim to them for you. In accordance with our contracts with all insurance companies, you are responsible for paying your portion at the time of service. Your estimated portion will be calculated by the benefit deductibles, co-pays, and/or a specific percentage your insurance company has established for your individual policy. A billing fee may be charged to your account if payment is not received at the time services are rendered. Please discuss and need for payment arrangements with our office manager before scheduling and appointment.

BILLING SCHEDULE: Statements will be mailed at the beginning of every month to patients with balances due by them after all Explanation of Benefits are received from your insurance company(s). If patient payments are not received after the first notice is sent to you, a billing fee may be charged to your account for every 30 days your account is past due. After 120 days of your first notice from our office your account may be turned over to a collection agency.

WORKERS COMPENSATION AND MOTOR VEHICLE COLLISION INJURIES: Please notify us if you have been injured on the job or in a motor vehicle accident. Worker's compensation does not cover necessary chiropractic treatments if your claim has been approved and is currently open. A new claim will require necessary forms to be completed by the patient and the doctor before it will be considered by the worker's compensation department. If your injury claim is not allowed, it is your responsibility to pay any outstanding balances. Your auto insurance company will pay for any necessary chiropractic treatment if you had "PIP" coverage (Personal Injury Protection) included in your auto policy at the time of the injury. You must file a claim with you auto insurance company and complete and return a "PIP" application to them before they will issue any payment towards your account. Workers compensation/Auto insurance policies will not cover any costs incurred by retail charges (i.e. braces, ice packs, etc.)

I have read the above policies of Haley Chiropractic Clinic and fully understand that I am responsible for the payment of my account. If a minor, a parent or guardian must sign this form.

PLEASE GIVE 24 HOURS NOTICE IF YOU ARE UNABLE TO MAKE YOUR SCHEDULED APPOINTMENT. NO SHOW APPOINTMENTS WILL BE SUBJECT TO A $25 NO SHOW FEE. PLEASE NOTIFY US OF ANY CHANGES TO INSURANCE, ADDRESS, OR PHONE NUMBERS PROMPTLY.

SIGNATURE _____ DATE_____

PATIENT NAME_____

IF MINOR, PARENT/GUARDIAN_____

AUTHORIZATION, ASSIGNMENT & RELEASE FORM

Patient Name_____ Date_____

I hereby authorize Haley Chiropractic Clinic to release any information deemed appropriate to my health insurance company and their affiliates, my auto insurance company and their affiliates, or my attorney and/or claims adjuster in order to process any claim for reimbursement of charges incurred.

In the event my insurance company or attorney does not pay Haley Chiropractic Clinic for services and/or product I receive. I understand that I am personally responsible to pay my account balance in full. I also understand that Haley Chiropractic Clinic will make all efforts in my favor to settle or resolve any said claim as we see fit.

In addition to the above, I waive the statute of limitations on collection in the state of WA. I agree that this authorization is irrevocable and ongoing until all monies owed are paid in full. This authorization will be in effect until revoked by both parties.

Our office is required by federal law to maintain the privacy of you Private Health Information (PHI). We will not share your PHI with other healthcare providers or persons unless you have granted us permission to do so.
I hereby give permission for Haley Chiropractic Clinic to share my PHI to the following health care providers and/or persons:

_____

_____

For a complete description of our practice's privacy notice, please ask at the reception desk. By signing below, I acknowledge I have read and understand the above terms.

SIGNATURE_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We keep a record of the care we give you. The record also contains other health information about you. We will not discuss your health information to others unless we have your permission to do so, or unless the law allows or requires us to do so. If you have questions about your health information or want to ask about your rights, contact:

Haley Chiropractic Clinic
1919 N. Pearl Street, Suite A4
Tacoma, WA 98406
(253)761-0930

By signing this form, you are letting everyone know that you received a copy of the Notice of Privacy Practices that explain your rights.

SIGNATURE_____ DATE_____

IF MINOR, PARENT/GUARDIAN_____ RELATIONSHIP_____