

Interurban Chiropractic

13028 Interurban Ave S. Suite 106
Tukwila, WA 98168-3340

Name _____ Gender _____ Gender Pronoun _____ Date _____

Address _____ City _____ State _____ Zip _____

H. Phone _____ W. Phone _____ Cell Phone _____

Date of Birth _____ Age _____ Marital Status M ☐ S ☐ D ☐ W ☐ P ☐ Social Security # _____

Email address: _____ Referred by: _____

Occupation _____ Employer _____

Insurance Company _____ ID# _____ Group# _____

Name of Insured: _____ Your relationship to Insured: _____

Emergency Contact _____ 1st Phone _____ 2nd Phone _____

Were you injured on the job? ☐ YES ☐ NO

Were you injured in an automobile accident? ☐ YES ☐ NO

Workers Comp Only Claim Number: _____

Date of Injury: _____

If yes, please stop and see the front desk for appropriate intake paperwork.

Purpose of this appointment: _____

Is there any pain present? (No complaint / pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain / Emergency)

How frequent is complaint present? _____ How long does it last? _____

Does anything aggravate the complaint? _____ Does anything make it better? _____

Please circle the type of the complaint/pain: dull ☐ achy ☐ sharp ☐ shooting ☐ burning ☐ throbbing ☐ deep ☐ nagging ☐ other _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? _____

Do you have any numbness, tingling, burning or weakness in your body? Where? _____

Have you lost any days from school/work? YES ☐ NO ☐ Dates: _____

Have you had this problem before? YES ☐ NO ☐ If so, when? _____ Is this condition: Worsening - Staying the Same - Improving

Have you consulted other doctors for this condition? YES ☐ NO ☐ Names and Dates: _____

Please check all that apply:

- ☐ Headaches
- ☐ Neck Pain
- ☐ Back Pain
- ☐ Nervousness
- ☐ Tension
- ☐ Irritability
- ☐ Chest Pains
- ☐ Dizziness
- ☐ Face Flushed
- ☐ Neck Stiff
- ☐ Pins & Needles in Legs

- ☐ Pins & Needles in Arms
- ☐ Numbness in Fingers
- ☐ Numbness in Toes
- ☐ Shortness of Breath
- ☐ Fatigue
- ☐ Depression
- ☐ Light Bothers Eyes
- ☐ Loss of Memory
- ☐ Ears Ring
- ☐ Fever
- ☐ Fainting

- ☐ Cold Sweats
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Diarrhea
- ☐ Feet Cold
- ☐ Hands Cold
- ☐ Stomach Upset
- ☐ Constipation
- ☐ Loss of Balance
- ☐ Buzzing in Ears
- ☐ Sleeping Problems

Please list any other Injuries, Traumas, Broken Bones and Surgeries you have had in the past, include dates:

Are you taking any medications or supplements? Please list: _____

Date of your last physical exam: _____ Height: _____ Weight: _____ Date of last chiropractic exam: _____

Females: Date of last menses: _____ Is there a possibility you could be pregnant? ☐YES ☐NO Please initial: _____

Any previous pregnancies? ☐YES ☐NO Any associated complications? Please list _____

Do you have any Allergies? ☐YES ☐NO Please list: _____

Family Health History:

Health problems of relatives: _____

Cause of parents or siblings death: _____

Age at death

6. Social and Occupational History:

A. Please describe your daily job duties: _____

B. What is your typical work schedule? _____

C. Recreational activities: _____

D. Please list your level of exercise, alcohol consumption, tobacco use and drug use: _____

Assignment and Release:

I have answered the questions on this form truthfully and to the best of my knowledge. I hereby authorize the doctors at Interurban Chiropractic Center to provide me with chiropractic care in accordance with this state's statutes. **I understand and agree that all services rendered to me are my financial responsibility and any health or accident insurance policies which I hold are based on a contract between the carrier and myself. I also understand that I am financially responsible for all non-covered services.** I assign to Interurban Chiropractic Center my insurance benefits and authorize this office to use my personal information in accordance with its privacy practices, which were presented to me with this form.

Patient or Guardian Signature _____ 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 out 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.

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

Printed Name

Interurban Chiropractic Center
Office Policies and Procedures

Symptoms: Regardless of the reason you came to our office, it is important to understand the difference between symptoms and their cause. As your spine is corrected you will have good days and bad days; it's normal. You will get the best results if you understand that this is a process designed to get you functioning and on the road to wellness. Stay focused on the outcome and you will be pleased with your results.

Appointments: A certain number of adjustments in a given time period is necessary to get the best results from your care. While we can't predict the exact number of adjustments you will need, we do know that consistency creates the best results. It is absolutely necessary that you keep your appointments. If you need to change an appointment, please call in advance to **reschedule** so that you can **stay on target for your wellness plan**. It is your responsibility to get here, but we will do all that we can to accommodate and help you on the way.

Re-Examinations: During your Initial Care, you will receive Re-Examinations to monitor your level of spinal correction. On this visit you will fill out an Update Form and the doctor will conduct a brief exam. Please plan on spending an extra 15 minutes on these days; they will be marked on your calendar.

Daily Visit Procedure: Each time you arrive for your adjustment, you will sign in at the front desk, pay any copays or balances owed, and will be directed to an Adjusting Room, or asked to have a seat if the rooms are full. Please, help yourself to our coffee station, read a magazine, or take care of any scheduling. Once you are in the adjusting room, sign in to the computer using your 10 digit pin code (your full cell phone number) and have a seat, the doctor will be with you shortly.

Results: We are result oriented, however, there are many factors that affect how quickly you respond to your care. Things that you cannot control include, but are not limited to: age, occupation, how long you've had your subluxations etc. Regardless, your body has an incredible ability to heal itself. The recommendations we make will consider these factors along with the current condition of your spine. We will do all that we can to get you to the Maintenance Stage of care as quickly as possible.

Massage: It is important to keep your massage appointments and to make sure that arrive on time for them. If you arrive late for a massage, it will cut into your appointment time and the massage will not be extended to compensate. If you need to cancel or reschedule, 24 business hour notice is REQUIRED to avoid a fee of \$95. If this happens more than 2 times you will be required to pay the \$95 and a \$95 time of service fee as a deposit before scheduling your next massage. If you pay the deposit and show up for your massage, you may carry it over as a deposit for the next massage you schedule. If you pay the deposit and miss the appointment, the deposit is not refunded and you will need to pay another \$95 to reschedule. X (Please initial here)

Please sign and date below to show that you have read and acknowledged Interurban Chiropractic's policies and procedures.

X _____
(Printed Name)

X _____
(Signature)

Date: / /



INFORMED CONSENT

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. When chiropractic care is chosen, it is essential to be working towards the same objectives and expectations, this prevents confusion and disappointment.

WE DO NOT OFFER DIAGNOSIS OR TREATMENT OF DISEASES, BUT RATHER WE WORK TO RESTORE FUNCTION TO THE BODY VIA PROPERLY FUNCTIONING SPINAL JOINTS SUPPORTING OPTIMAL NERVOUS SYSTEM FUNCTION.

Health is a state of optimal function, not merely the absence of disease. Our goal is to find, reduce and correct what is known as subluxation. Subluxation is misalignment of one or more of the vertebrae in the spinal column or bones of pelvis which can cause alteration of nerve function, reducing the body's innate health potential. The doctor will use their hands to correct malfunctioning joints known as subluxation. You may feel and/or hear the movement of the joints which may sound like "popping" your knuckles.

Overall, the risk of complications due to chiropractic care has been described as "rare" and it is considered one of the safest health care options. As with all types of health care interventions, there are some risks, including, but not limited to: fatigue, muscle soreness, muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement. Very rarely fractures, disc injuries, dislocations, strains & sprains may occur.

The association between visits to a chiropractor or a primary care physician and having a stroke is exceedingly rare and is estimated to be related in one in one million to one in two million visits. However, the literature recognizes a correlation between strokes and neck motions including chiropractic adjustments of the cervical spine. The best available scientific evidence supports the understanding that a chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. A dissection or arterial tear may result in the development of a clot that may lead to stroke. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis. Carotid and vertebral artery dissections are rare, with an annual incidence of 2.5 – 4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache.

Also know there are other treatment options available for you as well as getting second opinions. Likely, you've tried many of these approaches already including but not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections & surgery. Lastly, doing nothing could result in your condition worsening.

I have read the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient's Name Printed

SIGNATURE (signature of guardian if minor)

Date



Disclosure and Consent for Massage Therapy, Massage Cupping and Gua sha

Your massage therapist utilizes every available means, including written and verbal intake, and visual and tactile clues in order to give a safe and effective treatment. There is never any anticipation of adverse reactions from massage therapy but the following is to provide information for the patient about massage techniques and possible outcomes.

Massage therapy may include deep pressure, applied heat, stretching and percussion. Some possible reactions include the original pain not resolving, bruising, headaches or nausea. Massage Cupping and Gua Sha are therapeutic decompression techniques used by massage therapists, acupuncturists and body-workers for the relief of muscular pain, tension, and congestion. These techniques are used to draw out congested fluids and toxins to the surface tissue layers, allowing for fresh blood and lymph circulation. The resolution of stagnation and granulation in the tissues often brings an immediate relief from pain.

Massage Cupping uses negative pressure created within a specialized glass or rubber cup that is applied to the affected body part. The pressure can be deep to provide relief from tension, pain and injuries. Gentler pressure increases lymph flow, circulation and relaxation, and is excellent for facial treatments. Gua Sha is similar to cupping in results, but a round-edged tool is used in strokes to pressure specific areas of muscle pain.

There is a possibility of discoloration that can occur from the release and clearing of stagnation and toxins from the body. The reaction is not bruising, but the cellular debris, pathogenic factors and toxins being drawn to the subcutaneous layers for dissipation by the circulatory system. The discoloration, or *sha*, will dissipate in as soon as a few hours or up to 1 week, and in relation to after-care activities. It is important to drink plenty of water to stay hydrated, and avoid vigorous exercise for 24 hours after treatment.

Avoid exposure to extreme temperatures, including cold, wet and/or windy weather conditions, hot showers, baths, saunas, hot tubs, for 24 hours after treatment.

- I understand that all treatments at this facility are therapeutic in nature. I agree to communicate to the therapist any physical discomfort or draping issues during the session.
- If I choose to experience cupping therapy and/or Gua Sha during treatments, I understand the potential side-effects and the after-care recommendations.
- I also agree that I have read, understand and will follow all the information stated above and will not hold the practitioner responsible.

Signature

Date

Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical benefits, including major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Interurban Chiropractic for services rendered to myself and/or my dependents regardless of my insurance benefits, *if* any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Interurban Chiropractic to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Interurban Chiropractic on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Patient/Responsible Party Signature

Date