NEW BALANCE CHIROPRACTIC

10242 16th Ave SW Seattle, WA 98146 – (206) 764-9600

Name ____ Home Phone (_____)____________________ ☐ Male

Address ____ Day/Cell Phone (_____)__________________ ☐ Female

____ E-mail ________________________________ ☐ Single

Birthdate _____/_____/_____ SSN __________________ Occupation ____________________________ ☐ Married

Referred by Dr./Patient/Other ____ ☐ Other

Employer/School ____ Phone (_____)______________________

Spouse/Parent's Name ____ Phone (_____)______________________

Family Emergency Contact _____________________________________ Phone (_____)______________________

Non family Emergency contact __________________________________ Phone (_____)______________________

CURRENT/PAST HEALTH INFORMATION

Please list your current chief complaints in order of severity (pain, symptoms, etc.) Please complete diagram on the back.

1. ____ onset date____

2. ____ onset date ____

3. ____ onset date ____

What treatment have you received for your condition ☐ Medications ☐ Surgery ☐ Chiropractic Care

☐ Physical Therapy ☐ Massage ☐ Other

List other doctors consulted for these conditions: 1. __________________________ 2. ____________________________

Briefly describe **how, when & where** injury occurred: (e.g.: driving; on the job; at home, etc.)

____

____

What activities make your condition worse? ____

Have you ever had any surgeries or hospitalizations? _______ If yes, please list: ___________________________________

Please list any medical conditions not listed above: ____

Please indicate/list medications you are currently taking: ☐ Aspirin/Tylenol ☐ Pain killers

☐ Muscle Relaxers ☐ Birth Control Pills ☐ Others ____

Have you been involved in an auto accident in the last 12 months? ______ If yes, when? _________________________

FINANCIAL RESPONSIBILITY

☐ Auto accident ☐ Work injury ☐ Personal Insurance ☐ Self/Cash

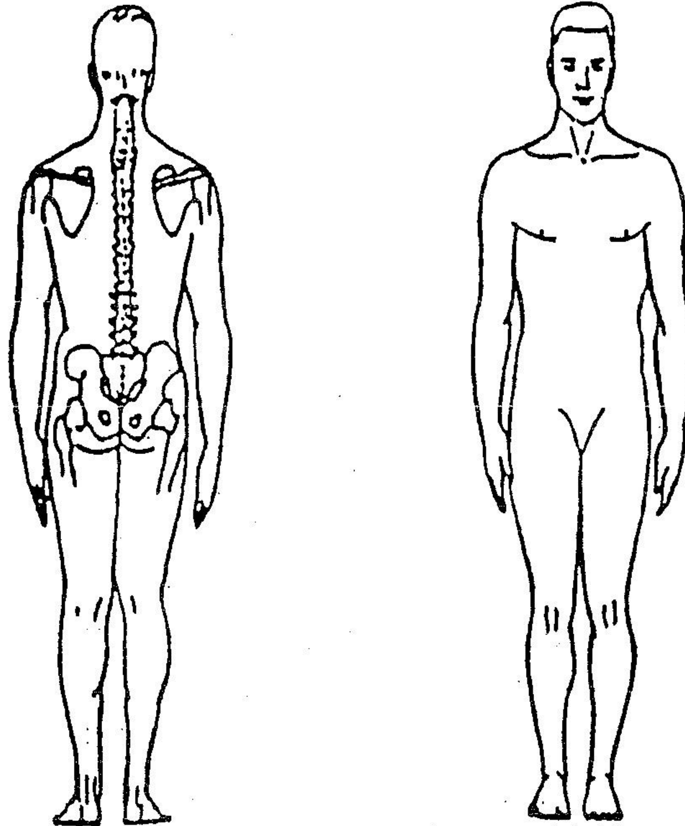
Insurance ____ ID /CLAIM ________________________________

Attorney ____ Phone ____________________________________

COMPLETE THESE DIAGRAMS

Please circle areas of chief complaint as indicated on the front of this form.

If you are experiencing any health problems**, please mark the exact location of your pain.** Also describe **the type and frequency** of your pain. (e.g.: dull, sharp, constant, off and on, when standing, sitting, walking etc.)



NOTICE: NOT ALL PATIENTS REQUIRE X-RAYS TO DETERMINE OR VERIFY A DIAGNOSIS, TYPE AND LEGNTH OF TREATMENT. IF YOUR EXAMINATION WARRANTS X-RAY ANALYSIS, THE FOLLOWING OFFICE POLICY PREVAILS:

1. All first visit charges are payable when services are rendered.

2. The fee paid for x-rays is for analysis only. The film itself is the property of this office. Once films are used for the purpose of analysis, they can be temporarily released upon your signed release.

____

Patient Signature Date

____

Parent or Guardian Signature Date

New Balance Chiropractic

10223 16th Ave SW
Seattle, WA 98146
(206) 764-9600
(206) 762-6600

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

In the course of your care as a patient at New Balance Chiropractic we may use or disclose personal and health related information about you in the following ways:

- Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may responsible for the payment of services provided to you.
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. ***You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.***

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another authorized agency

You have a right to receive an accounting of any such disclosures made by this office.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. ***If you provide an authorization for release of information you have the right to revoke that authorization at a later date.***

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. ***If you would like to receive this information at an address other than your home or if you would like the information in a specific form, please advise us in writing as to your preferences.***

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to **Christopher V. Hill, D.C.**

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. ***If you choose to lodge a complaint with this office or with the Secretary your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.***

This office utilizes an "open-adjusting" environment for ongoing patient care. "Open adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and this is NOT the environment used for taking patient histories, providing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment other arrangements will be made for you.

This notice is effective as of . This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. ***My signature acknowledges that I have received a copy of this notice.***

_____________________________ _____________________________ ______________

Printed Name Signature Date

If you are a minor, or if you are being represented by another party

_____________________________ _____________________________ ______________

Personal Representative (Printed) Personal Representative (Signature) Date

____

Description of the authority to act on behalf of the patient.

Patient Authorization for appointment reminders and scheduling related matters
This authorization allows us to contact you through the use of your name, address, e-mail and / or phone number to remind you of scheduled appointments, re-evaluations or other appointment related issues.

Patient Authorization for use of name for Referral Board
This authorization allows us to place your name on our "Thank you for your referral board" should you refer friends, family or coworkers to our office.

Patient Authorization for use of name and address for internal office mailings
This authorization allows us to mail / e-mail you health related information, newsletters, or direct mail correspondence for the purpose of education, updating you on legislative activities related to your health care, promotions, special offers, etc.

The use of this information is intended to make your experience with our office more efficient and productive. If you choose not to authorize the use of this information your decision will have no adverse effect on your care at New Balance Chiropractic or on your relationship with our staff.

Your signature indicates your authorization of this activity.

____

Name (printed)

____ _____________

Signature Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow us a reasonable processing time for the change in our procedures to be completed.

New Balance Chiropractic

TERMS OF ACCEPTANCE

In the course of chiropractic health care, it is essential for the physician and patient to work towards the same objective. As a patient, you should understand the goal and methods of chiropractic that will be used in order to avoid confusion or disappointment.

Adjustment:
An adjustment is the specific application of forces to facilitate the body's collection of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health:
A state of optimal physical, mental and social well-being, not just the absence of infirmity.

Vertebral Subluxation:
A misalignment of one or more of the 24 vertebra in the spinal column (which causes alteration of nerve function and interference to the transmission of mental impulses), which can impair the body's ability to achieve maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

We do not offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is adjusting to correct vertebral subluxations.

I, ________________________ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

__________________________________ ____________________
(Signature) (Date)