Mount Vernon Chiropractic, Inc., P.S.

CASE HISTORY

PATIENT INFORMATION: **Today's Date**_____

Patient Name_____ Date of Birth _____
Physical Address _____
City_____ State_____ Zip _____
Cell Phone #_____ Home Phone #_____
E-mail_____

Emergency Contact_____Telephone Number_____

Interpreter name and phone # (if applicable)_____
Sex (Circle) Male Female Marital Status (Circle) Single Married Divorced Other

Social Security Number_____ _____ _____

Employer/Company Name _____
Employer Address_____
Occupation_____

Past Chiropractic Care_____When_____

Are your complaints due to any injury: ☐ No ☐ Yes ☐ On the Job ☐ Auto Accident

Chief Complaints 1._____How Long_____
2._____How Long_____
3._____How Long_____

Have You Ever Had Any Of The Following Problems? Please Explain
☐ Cardio-Vascular_____
☐ Respiratory_____
☐ Cancer_____
☐ Mental Disorder_____
☐ Gastro-Intestinal_____
☐ Skin or Allergy_____
☐ Other_____
Have you had any operations? Please list dates _____
_____

List any prior accidents or falls ☐ Car_____ ☐ Recreational Vehicle_____
☐ Sports_____ ☐ Work Accidents_____ ☐ Other_____

Have you had any broken bones or been on crutches? _____
Have you had any spinal taps or spinal injections? No ☐ Yes ☐ When and Why?_____
Have you ever been unconscious?_____
Have you had x-rays or other imaging taken? No ☐ Yes☐ When_____ Where_____

I hereby authorize the Doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care, and I give authority for procedures to be preformed. It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time. The Doctor will not be held responsible for any pre-existing medically diagnosed condition.

By signing below, I acknowledge that I understand the policies as contained herein.

Patient's/Guardian's Signature_____Date_____
Witness:_____Date_____

For Doctor's Use Only

MOUNT VERNON CHIROPRACTIC

1600 Roosevelt Avenue, Suite A
Mount Vernon, WA 98273
360-428-0304

Release of Health Care Information to Someone Other than Myself

I,_____allow the following person(s) to have access to my private health care information. (Examples are spouse, child, aunt, etc.)

The Doctors and staff at Mount Vernon Chiropractic are allowed to disclose:
☐ financial information only ☐ information concerning my condition being treated
☐ any information in my records (including appointments)
☐ All of the above

To the following person(s)
- ☐ My spouse/significant other or immediate family member
- ☐ Family Member Name: _____
- ☐ My attorney
- ☐ Other _____

If at any time, the patient chooses to no longer have this information disclosed, please inform Mount Vernon Chiropractic immediately.

_____ _____
Date Print Name Signature

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Authorization for Treatment of Minor

I, _____ being the parent or legal guardian of _____ have read and fully understand the "Informed Consent" and hereby grant permission for my child to receive chiropractic care, which may include x-rays. I acknowledge and accept the responsibility of the fees incurred.

_____ _____
Date Print Name Signature

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Verification of Non-Pregnancy

This is to certify that to the best of my knowledge I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. The above doctor and his/her associates have my permission to perform x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

_____ _____
Date Print Name Signature

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Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. **Health** is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a **vertebral subluxation**. This occurs when or more of the 24 vertebrae in the spinal column becomes misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment**. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be preformed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of these findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me and to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

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FINANCIAL POLICIES

For your convenience, we accept Cash, personal checks, debit cards, and Visa, American Express, and MasterCard. Payment for services provided is expected at the time of the service.

As a courtesy to our patients we will bill your insurance company, however, the patient is always responsible for payment of their care. An insurance contract is between the patient and the insurance company. **Insurance coverage is never guaranteed**. Your insurance company determines benefits when they receive our billing. Any statements made by our staff regarding your coverage in no way guarantees that your care with Mount Vernon Chiropractic will be covered by your insurance company. If there are any problems with the insurance company making payments for your care, please ask us how we can help.

Your signature below assigns Mount Vernon Chiropractic for collection of benefits and also authorizes Mount Vernon Chiropractic to release daily chart notes at our discretion when necessary to your insurance company.

Active monthly payments are requested. Accounts with balances 30 (thirty) days past due may be charged a service fee of 12% per year compounded monthly. Accounts where no payment has been received for 60 (sixty) days may be sent to a third party collection agency. Any additional collection fees will be the responsibility of the patient.

NSF checks or rejected credit card payments may be charged a service fee of $35 per occurrence.

We do offer a time of service discount when services are paid in full at the time of the visit. If we are contracted with your insurance company, we are obligated to abide by the billing policies set forth by that insurance company. These policies vary widely with each insurance company, and if Mount Vernon Chiropractic has a contract with your insurance company, it may mean we cannot offer you our time of service discount. We understand insurance policies can be confusing and we encourage your questions. Please ask our staff for clarification on any of these policies.

Mount Vernon Chiropractic offers a pre-payment time of service package as well for your convenience. This package is refundable for the unused visits. Please ask us for details.

Our goal is to provide excellent chiropractic care and minimize financial surprises as best we can. We can help you with your questions and concerns. Please ask us if you have any questions regarding these matters.

Your signature below acknowledges that you agree and accept Mount Vernon Chiropractic's financial policies. We understand you have many choices for your healthcare needs. Thank you for choosing us to provide your care.

Signature (Parent or Guardian signature if a minor) **Date**

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NOTICE OF PRIVACY PRACTICES

Mount Vernon Chiropractic uses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care you receive.

Mount Vernon Chiropractic will not disclose your information to others unless you authorize it in writing, or unless required by law.

Mount Vernon Chiropractic may use your information to provide appointment reminders, information about treatment alternatives, or other health related issues. Mount Vernon Chiropractic may disclose your information for public health activities such as funeral directors, organ/tissue donations, research, health and safety, and to comply with workers compensation requirements.

Mount Vernon Chiropractic must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices, abide by the terms of this notice, notify you if we are unable to agree to the requested restriction, accommodate reasonable requests to receive your information by alternative means or at alternative locations, and obtain your written authorization to use or disclose your health information for reasons other than those listed and permitted under law.

You have a right to restrict some information, report and retain a copy of your health record, request communication of your information by alternative means or alternative locations, or revoke your authorization and request an accounting of your health records. You may bring questions, suggestions or complaints to our Privacy Officer, Ally Olson and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

If you have questions, complaints, or suggestions, please contact Ally Olson at 360-428-0304.

NO SHOW AND LATE CANCELLATION POLICY

We understand that special circumstances do arise. **Please give 12-24 hours' notice whenever possible** if you find yourself unable or unwilling to keep your appointment for any reason. We respect your schedule and make every effort to minimize waiting time during your visits to our office.

We allow one no show or late cancellation per calendar year as a courtesy to you. We may assess a $20 fee for future no shows or late cancellations within that calendar year.

You are a valued patient and our goal is to keep costs down while providing the best care possible. We have these policies in place so that we can respect the time of all of our patients, our staff and our doctors.

I have read and understand the above policies.

Signature (Parent or Guardian signature if a minor) **Date**