EVERETT SPINE & REHAB
Chiropractic
Physical Therapy
Massage Therapy
Acupuncture
Naturopathic Medicine

927 128th St. SW. Suite B
Everett, WA 98204
P: (425) 347-8614
F: (425) 348-6986
www.everettspinerehab.com

NEW PATIENT INTAKE FORM

PATIENT INFORMATION

Name: _____

Sex: ☐ M ☐ F Age: _____ Birthdate: _____

Address: _____

_____

SSN #: _____

E-Mail Address: _____

Ph #: _____ Work Ph #: _____

Automated Message Reminder? ☐ Cell Ph. Text ☐ E-mail ☐ No

Cell Ph. Service Provider: _____

(You will receive an appointment reminder one day before your scheduled visit).

Your Employer: _____

Employer Ph #: _____ Occupation: _____

Employer Address: _____

EMERGENCY CONTACT INFORMATION

Name: _____

Phone: _____ Work Phone: _____

Relationship to patient: _____

INSURANCE INFORMATION

Insurance Company: _____

Insurance ID #: _____

Group #: _____

Subscriber's Information (if different) Name: _____

Birthdate: _____ SSN#: _____

Relation to patient: _____

Is patient covered by additional insurance? ☐ Yes ☐ No

_____

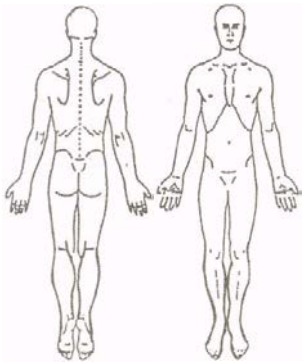
PATIENT CONDITION

Reason for visit: _____

When did your symptoms appear? _____

Is your condition getting worse? ☐Yes ☐ No ☐ Unknown

Mark X on the picture where you continue to have pain, numbness or tingling.



Rate your severity on a scale from:
1 (least pain) to 10 (most pain) _____

Types of pain: ☐ Sharp ☐ Dull
☐ Throbbing ☐ Numbness ☐ Aching
☐ Shooting ☐ Burning ☐ Tingling
☐ Cramping ☐ Stiffness ☐ Swelling

How often do you have pain? _____

Is your pain constant or does it go away? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Recreation ☐ Other

Activities or movements that are painful to perform are:

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down

_____

_____

ACCIDENT INFORMATION

Is your condition due to an accident? ☐ Y ☐ N

Date of Injury: _____

Type of accident? ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you reported this accident to? _____

☐Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable): _____

Attorney Address: _____

Attorney Phone: _____

PHYSICIAN & REFERRAL INFORMATION

Primary Care Physician's Name: _____ Phone #: _____ Fax #: _____

Clinic Name: _____ Address: _____

Referring Physician (if different than above): _____

To whom may we thank for referring you to our clinic? _____

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HEALTH HISTORY

What treatments have you already received for your condition? ☐ Medication ☐ Surgery ☐ Chiropractic ☐ Massage ☐ Physical Therapy

Name and address of other doctor(s) who have treated you for your condition: _____

_____

Date of last: Physical Exam _____ Spinal X-ray _____ Blood Test _____

Spinal Exam _____ Chest X-ray _____ Urine Test _____

Dental X-ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "YES" or "NO" to indicate if you have had any of the following:

AIDS / HIV ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	Miscarriage ☐ Yes ☐ No	Scarlet Fever ☐Yes ☐No
Alcoholism ☐ Yes ☐ No	Epilepsy ☐ Yes ☐ No	Mononucleosis ☐ Yes ☐ No	Stroke ☐Yes ☐No
Allergy Shots ☐ Yes ☐ No	Fractures ☐ Yes ☐ No	Multiple Sclerosis ☐ Yes ☐ No	Suicide Attempt ☐Yes ☐No
Anemia ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Mumps ☐ Yes ☐ No	Thyroid Prob. ☐Yes ☐No
Anorexia ☐ Yes ☐No	Goiter ☐ Yes ☐ No	Osteoporosis ☐Yes ☐ No	Tonsillitis ☐Yes ☐No
Appendicitis ☐ Yes ☐ No	Gonorrhea ☐ Yes ☐ No	Pacemaker ☐ Yes ☐ No	Tuberculosis ☐Yes ☐No
Arthritis ☐ Yes ☐ No	Gout ☐ Yes ☐ No	Parkinson's Dis. ☐ Yes ☐ No	Tumor Growth ☐Yes ☐No
Asthma ☐ Yes ☐ No	Heart Disease ☐ Yes ☐ No	Pinched Nerve ☐ Yes ☐ No	Typhoid Fever ☐Yes ☐No
Bleeding Disorder ☐ Yes ☐ No	Hepatitis ☐ Yes ☐ No	Pneumonia ☐ Yes ☐ No	Ulcer ☐Yes ☐No
Breast Lump ☐ Yes ☐ No	Hernia ☐ Yes ☐ No	Polio ☐ Yes ☐ No	Vaginal Infect. ☐Yes ☐No
Bronchitis ☐ Yes ☐ No	Herniated Disk ☐ Yes ☐ No	Prostate Problem ☐ Yes ☐ No	Venereal Dis. ☐Yes ☐No
Bulimia ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Prosthesis ☐ Yes ☐ No	
Cancer ☐ Yes ☐ No	High Cholesterol ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	Alcohol Abuse ☐ Yes ☐ No
Cataracts ☐ Yes ☐ No	Kidney Disease ☐ Yes ☐ No	Rheumatoid Arth. ☐ Yes ☐ No	Drug Abuse ☐ Yes ☐ No
Chicken Pox ☐ Yes ☐ No	Measles ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No	
Diabetes ☐ Yes ☐ No	Migraine Headache ☐ Yes ☐ No	Other: _____	

EXERCISE
- ☐None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS
- ☐ Smoking Packs/Day: _____
- ☐ Alcohol Drinks/Week: _____
- ☐ Coffee/Caffeine Drinks Cups/Day: _____
- ☐ High Stress Level Reason: _____

ARE YOU PREGNANT? ☐ Yes ☐ No Due Date: _____ Name of OBGYN: _____

PRIOR INJURIES / SURGERIES

Falls _____

Head Injuries _____

Broken Bones _____

Dislocations _____

Surgeries _____

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LIST OF MEDICATIONS	LIST OF ALLERGIES	LIST OF SUPPLEMENTS TAKEN

FOR PATIENTS OF NATUROPATHIC MEDICINE

Please list important medical conditions for each family member below:

Mother: _____

Father: _____

Maternal Grandmother: _____

Maternal Grandfather: _____

Paternal Grandmother: _____

Paternal Grandfather: _____

Siblings: _____

Additional Notes:

_____

_____

_____

_____

_____

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PERSONAL INJURY (MOTOR VEHICLE COLLISON) QUESTIONNAIRE

PATIENT INFORMATION

Patient Name: _____ Phone: _____
Employer's Name: _____ Employer's Address: _____
Name on Policy (if other than self): _____ Policy #: _____
Your Insurance Co.: _____ Ins. Agent's Name: _____ Claim # _____
Responsible Party's Name: _____ Address: _____
City: _____ State: _____ Zip: _____
Your attorney's name: _____ Phone: _____

INFORMATION ABOUT YOUR MOTOR VEHICLE COLLISON

1. Date of crash: _____ Approx. Time of Day if Known: _____
2. Time of Day? ☐ Daylight ☐ Dawn ☐ Dusk ☐ Night
3. Visibility? ☐ Clear ☐Sunny ☐Cloudy ☐Hazy
4. Foggy road conditions? ☐Dry ☐Damp ☐Wet
5. Were You? ☐Driver ☐Passenger ☐Front Seat ☐Back Seat ☐Motorcycle Operator
6. If you were the driver, were your hands: ☐One on wheel ☐Two on wheel
7. Number of People in the vehicle? : _____
8. Your vehicle (year, make, model): _____
9. Other vehicle (year, make, model): _____
10. Your estimated speed at moment of crash: _____ ☐Stopped ☐Slowing ☐Accelerating
11. Other vehicle estimated speed at moment of crash: _____ ☐Stopped ☐Slowing ☐Accelerating
12. Your vehicle was struck? ☐Yes ☐No Or did you hit the other vehicle? ☐Yes ☐No
13. Were you struck from: ☐Behind ☐Front ☐Left Side ☐Right Side
14. Were your brakes applied? ☐Yes ☐No
15. Were you wearing your seat belt? ☐Yes ☐No
16. Were you caught by surprise by the impact / crash? ☐Yes ☐No
17. Did you know that you were about to be hit by another vehicle? ☐Yes ☐No
18. How did you know? _____
19. What position was your headrest / restraint in? ☐Up ☐Down ☐Don't know
20. Is your headrest adjustable or fixated to the seat? ☐Adjustable ☐Fixated to the Seat
21. Did the back of your head come in contact with the headrest? ☐Yes ☐No
22. Did your head jerk forward and backward over the headrest? ☐Yes ☐No
23. Do you sit with your seat reclined? ☐Yes ☐No ☐Somewhat ☐A lot
24. Did your body jerk forward or side to side from the impact? ☐Yes ☐No
25. Did your airbag deploy? ☐Yes ☐No
26. Were you hit by the airbag? ☐Yes ☐No ☐Don't know

27. Was the seat back adjustment altered by the crash? ☐Yes ☐No
28. Did the seat break? ☐Yes ☐No ☐Don't know
29. Did you reposition your seat after the crash? ☐Yes ☐No ☐Don't know
30. Was your head turned at impact? ☐Yes ☐No ☐Left ☐Right ☐Up/Down ☐Don't know
31. Were you knocked unconscious? ☐Yes ☐No ☐Don't Know
32. Did you strike any part of vehicle? ☐Yes ☐ No _____
33. Wearing a hat or glasses? ☐Yes ☐No Still on after crash ☐Yes ☐No
34. Were police notified? ☐Yes ☐No Is there a crash report? ☐Yes ☐No
35. Do you have a copy of the report? ☐Yes ☐No If yes, please bring it in.
36. Were there any witnesses? ☐Yes ☐No Names? _____

37. In your own words, please describe the crash:

_____

_____

_____

_____

38. Did you have any physical complaints BEFORE THE CRASH? ☐Yes ☐No
    If yes, please describe: _____
39. Please describe how you felt:
    a. DURING the crash: _____
    b. IMMEDIATELY AFTER the crash: _____
    c. LATER THAT DAY: _____
    d. THE NEXT DAY: _____

40. What are your PRESENT complaints and symptoms? When do they appear?

_____

_____

_____

_____

41. Do you have any congenital (from birth) factors which relate to this problem?

_____

42. Do you have any previous injuries or illnesses which relate to this case? ☐Yes ☐No
43. Have you ever been involved in a crash before? ☐Yes ☐No
    If yes please describe: _____
44. Concerning this most recent crash, did you go to the hospital? _____
45. Were you taken by ambulance? ☐Yes ☐No Taken by: ☐Family ☐Friend ☐Yourself
46. Have you been treated by another doctor(s) since the crash? ☐Yes ☐No
47. If yes, what Doctor(s)? _____
48. Since the injury occurred, are your symptoms ☐Improving ☐Getting Worse ☐Same
49. Do you notice any activity restrictions as a result of this injury? ☐Yes ☐No
50. If yes, please describe: _____

51. Have you lost time from work as a result of this Crash? ☐Yes ☐No

a. Last day worked: _____

b. Type of employment: _____

c. Present Salary: _____

d. Are you being compensated for time lost from work? ☐Yes ☐No

52. Other pertinent information: _____

_____

_____

_____

CIRCLE ALL SYMPTOMS YOU HAVE NOTICED SINCE THE CRASH:

Headache	Irritability	Numbness-Toes	Ringing in Ears
Neck Pain	Chest Pain	Numbness-Fingers	Buzzing in Ears
Neck Stiff	Dizziness	Fatigue	Shortness of Breath
Sleep Disturbance	Head is Heavy	Depression	Fainting
Upper Back Pain	Numbness Arms	Light Sensitive Eyes	Loss of Balance
Low Back Pain	Numbness Legs	Sensitive to Noise	Loss of Smell
Nervousness	Pin/Needles Legs	Loss of Memory	Loss of Taste
Tension/Anxiety	Pins/Needles Arms	Fainting	Diarrhea
Feet Cold	Upset Stomach	Cold Sweats	Fever
Hands Cold	Constipation	Other: _____	

_____

Printed Name Signature Date

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DISCLOSURE REGARDING USE OF MEDICAL LIENS AS PART OF BILLING AND COLLECTION PRACTICES

I understand that for treatment provided by Everett Spine & Rehab (ESR) are related to an automobile collision, the primary first party insurance is with the Personal Injury Protection (PIP) Insurance for the car I was driving, riding in as a passenger, or struck by as a pedestrian/bicyclist. I understand and authorize ESR to bill PIP and authorize the release of any information acquired in the course of my examinations and treatment in accordance with HIPAA privacy regulations.

Should PIP insurance not be available, exhausted or terminated for any reason, I authorize ESR to bill any applicable health insurance I may have available— subject to any contract ESR may have with said carrier. I understand and authorize ESR to bill health insurance, if applicable, and authorize the release of any information acquired in the course of my examination and treatment in accordance with HIPAA privacy regulations.

In the event I do not have PIP or health insurance available for the automobile collision, I authorize ESR to hold my bills pending final claim resolution and file a medical lien against any applicable third-party insurance settlement pursuant to RCW 60.44.010, et seq. I understand I may then be asked to make minimum monthly payments on any balance owed.

I understand and acknowledge that in the event a medical lien is filed, and that if the lien is paid or settled, I will be provided with an original and written Satisfaction of Lien. I am responsible for filing the Satisfaction of Lien with the County Auditor and for paying the filing fee costs associated with filing any such Satisfaction of Lien. I further understand that payment of any medical lien, in some circumstances, may not fully pay my outstanding final charges due to ESR for treatment provided, and I may be required to make additional payments after the satisfaction of the lien.

Dated this _____ day of_____, 20__, at _____, Washington.

_____

Printed Name Signature

_____

Date of Automobile Collision

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NOTICES OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. IT ALSO DESCRIBES HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. If you have any questions about this notice, please contact our Privacy Officer at (425) 347-8614.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This notice applies to all of the records of your care generated by the clinic, whether made by clinic personnel or other providers involved in your care.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information. However, the usage and disclosure of your private healthcare information (PHI) is not limited to this list.

For Treatment:	We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to other healthcare providers from whom you are receiving treatment (e.g. diagnostic centers, physician's clinics, hospitals, specialists, etc.)
Interpreters:	We may share your medical information with interpreters to assist in scheduling appointments and providing treatment to you.
For Payment:	We may use and disclose medical information about you so that the treatment and services you receive at the clinic may be billed and also to receive payment from you, insurance companies, third parties, or other financially responsible parties.
Appointment Reminders:	We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the clinic. Your signature indicates your consent to receive messages and/or correspondence via the method of contacts you have given us.
Family, Caregivers, etc.:	We may release medical information about you to a caregiver who may be a friend or family member. We may also give information to someone who helps pay for your care, or whom you have identified as being involved in/responsible for your care.
As Required By Law:	We will disclose medical information about you when required to do so by federal, state or local laws.
Military:	If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.
Workers' Compensation:	We may release medical information about you for workers' compensation or similar programs, as applicable.
Public Health Risks:	We will share your health information when the law requires us to do so in the following applicable circumstances, which include but are not limited to: reporting public health threats such as infectious diseases, reporting suspected abuse, violence, or neglect victims, or to provide health information about you to protect the health and safety of yourself and others.

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YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. To inspect and/or copy your personal medical information, please submit your request in writing with your signature authorizing release of information. If you request a copy of your health information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. Your request may take up to 15 business days to be fulfilled. We may deny your request to inspect and copy in certain, very limited circumstances.

Right to Amend: You may request that we correct your health information that we have created if the information is wrong or incomplete. Correction requests must be submitted in writing with an explanation of why you want the information changed. Your request may be denied if the information is correct or was not created by Everett Spine & Rehab.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we have made of medical information about you to others except for purposes of treatment, payment and operations as identified above. To request an accounting of disclosures, you must submit your request in writing to the Clinic Manager. Your request must state a time period which may not be longer than six years.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree with your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Clinic Manager. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; (3) to whom you want the limits to apply; for example: disclosures to your spouse.

Confidential Communications: You may specify where and how our staff may contact you, such as only at work or by mail. Submit your request in writing, stating how or where you wish to be contacted, including all pertinent contact information.

CHANGES TO THIS NOTICE:
We reserve the right to change this notice and to make the revised or changed notice effective for medical information we already have about you as well as information we receive in the future. When you register at the clinic, we will offer you a copy of the current notice in effect. You may request a copy of this or any future notice from the Privacy Officer.

If you believe your privacy rights have been violated, you may contact the Privacy Officer or submit your complaint in writing. If we cannot resolve your concern, you also have the right to file a written complaint with the Secretary of the Department of Health and Human Services. The quality of your care will not be jeopardized nor will you be penalized for filing a complaint.

ACKNOWLEDGEMENT OF RECEIPT: My signature below acknowledges that this two page Privacy Policy notice has been given to me to review and that, thereby, I have been offered and received a copy if I so desire.

Printed Name Signature Date

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CONSENT TO RECEIVE CARE & ASSIGNMENT OF PAYMENTS

I hereby voluntarily consent to the rendering of examinations, diagnoses, and treatments by authorized members of the Everett Spine & Rehab staff or their designees, as deemed in their professional judgment to be necessary. I do not expect the provider to be able to anticipate and explain all risks and complications, and I wish to rely on their exercise of judgment based on the facts then known – that it is in my best interest. I understand and I am informed that in the practice of chiropractic, physical therapy, acupuncture, naturopathic medicine, and/or massage therapy there is a possibility, although unlikely, of adverse events from examination and/or treatment (including, but not limited to; soreness, headaches, fractures, disc injuries, strokes, bruising, flu-like symptoms, dislocations, sprains, and increased symptoms in pain or no improvement in symptoms or pain). I agree that if I suspect any adverse events that I will inform my provider.

I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatments. I also understand that my therapist cannot diagnose illnesses or prescribe medical or pharmaceutical treatments. I intend this Consent to Receive Care form to cover the entire course of treatment and my present condition as well as for any other condition(s) for which I seek treatment in the future. I understand that I may refuse treatment at any time and that I am responsible for my own healthcare choices or decisions.

I understand that payment for services rendered to me is ultimately my responsibility and that payment is due upon receipt of services unless arrangements are made in advance. I hereby instruct and direct my insurance company or their intermediaries to pay for services rendered to the providers at Everett Spine & Rehab and to be mailed at 927 128th St S.W. Suite B, Everett, WA 98204 (for the professional medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment towards the total charges for services provided). This is a direct assignment of my insurance benefits. This payment will not exceed indebtedness to the providers at Everett Spine & Rehab. I agree to cooperate with the office, and furthermore instruct my attorney to pay any balances due to this office directly at 927 128th St S.W. Suite B, Everett, WA 98204.

- I understand that the office will assess, at their discretion, a cancellation fee or charge me the full service fee if I do not give notice of cancellation of my appointment at least twenty-four hours in advancement.

- I understand there is no guarantee that my insurance companies or pre-paid health plan will cover or pay for all of my charges, and that should I fail to pay outstanding charges, Everett Spine & Rehab may opt to utilize a collection agency.

- Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all charges. A photocopy of this assignment shall be considered as effective and valid as the original document.

By signing below, I understand the terms above and agree to the Consent to Receive Care and Assignment of Payments.

Printed Name Signature Date

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APPOINTMENT CANCELLATION POLICY AGREEMENT

As a multi-discipline facility, our goal is to provide quality care and to respect our patient's appointment times. If an appointment is made at Everett Spine & Rehab, our staff diligently works to manage patient schedules, provide appointment reminders to patients, and they also can establish a text message or e-mail appointment reminder option upon request. Please note: automated appointment reminders are sent out one day before your scheduled visit. If requested, patients who are frequently seen can be provided with a printout of their appointments.

Cancellation of an Appointment (24 Hour Notice Is Required)

- Please be courteous and promptly call Everett Spine & Rehab if you are unable to attend an appointment.
- Appointments are in high demand and your early cancellation will give another patient the possibility to have timely access to care.

How to Cancel Your Appointment

- To cancel appointments, please call us during our hours of operation at: 425-347-8614 | Monday through Friday | 9am-6pm.
- If you have an emergency, and are unable to reach a front desk staff member, please leave a detailed message on our voicemail system.

Late Cancellations

- Late cancellations will be considered as a "no-show".

No Show Policy Details

- A no-show patient is one who misses an appointment without providing a 24 hour notification.
- This policy will be waived in cases of emergencies (i.e. if there is adequate proof of the emergency).
- Failure to be present for a scheduled appointment will be recorded in the patient's chart as a "no-show".
- An updated address reverification/phone contact form may be requested by the patient care coordinator to the patient.

No Show Policy Fees

- A $25.00 fee charge will be issued to a patient who continuously no-shows.
- Five "no shows" will result in the temporary suspension of services. In order to reinstate service, the patient will be required to meet with the Office Manager to evaluate their situation.

Walk-Ins

- We realize that illnesses and accidents often occur unexpectedly. In an effort to provide the convenience of timely care – we offer walk-in visits. Unless you have scheduled appointments, all care is provided on a first come, first serve basis.
- All emergencies will be given utmost priority.

By signing below, I understand the terms above and agree to the Appointment Cancellation Policy.

Printed Name Signature Date