Firefly Light Therapy Evaluation
112 Avenue D, Suite A, Snohomish, WA 98290
Tel: (360) 863-2412

CLIENT INFORMATION

Name: ____

Address:____City:_______________________

Zip: ________________________ Home/Cell Phone: _______________________________________

Email Address: ____

Birthdate: ___________________ Age: __________ Gender: ☐ Male ☐ Female

Pronoun: _____________________

Occupation: _________________________ Employer: ______________________________________

How were you referred to Firefly Light Therapy Treatment? :

☐ Family Member ☐ Friend ☐ Doctor: ____

☐ Other: ____

In event of an Emergency

Name: ____ Relationship to Client: _______________

Home Phone #: _______________ Cell#: ____________________ Work#: _______________________

Informed Consent For Firefly Therapy

Firefly therapy utilizes packets of light called Photons to stimulate blood circulation to the treatment area. This results in relief of pain and reduction of symptoms associated with soft tissue injury, such as swelling. Firefly therapy also decreases the healing time associated with superficial injuries, such as burns, cuts, and contusions.

Adverse effects from Firefly therapy are normally rare and temporary. These effects may include from multiple sources, in most cases involving hypersensitivity to light, preexisting medical conditions, thermal effects, excessive pressure from the treatment unit, and overstimulation. **Firefly therapy can cause serious damage to the eye; therefore, it is very important to wear protective glasses that will be provided at all times during treatment**.

Although Rare, the most common adverse effects to Firefly therapy are:

1.) Temporary increase in pain during Firefly application

2.) Temporary increase in pain in the day or days following Firefly therapy

3.) Mild bruising from stimulation of blood circulation or direct pressure of treatment unit

4.) Temporary dizziness

5.) Reactions when photosensitizing drugs are used with Firefly Therapy

I have read and understand the risks of Firefly therapy. I agree to wear the protective glasses provided to me at all times during my treatment

Patient Signature: ____ Date: ________________

Briefly describe your current symptoms? ____

____

When did your symptoms start? ____

____

Please mark the location where you have the pain or other symptoms.

Please describe your symptom(s).

☐ Sharp ☐ Dull Ache ☐ Numb ☐ Shooting

☐ Burning ☐ Tingling ☐ Other ____________________

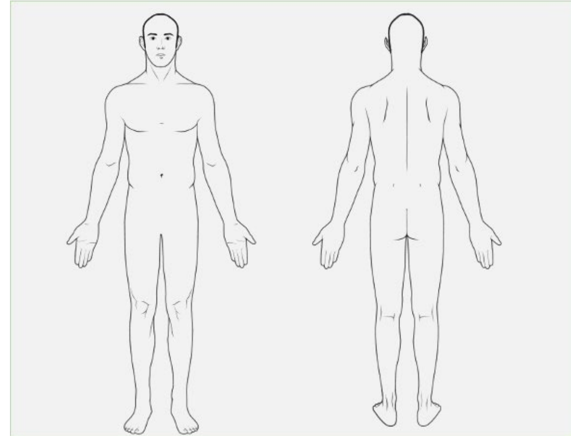
Since your symptom(s) began, are they …

☐ Increasing ☐ Decreasing ☐ Not changing

How often do you experience your symptom (s)?

☐ Constantly (76% - 100%) ☐ Frequently (51% - 75%)

☐ Occasionally (26% - 50%) ☐ Intermittently (0% – 25%)



If anything, what makes this better? _________________

____

If anything, what makes this worse?_______________

____

None Unbearable

Rate the severity of your pain in the last 24 hours

0 1 2 3 4 5 6 7 8 9 10

0 1 2 3 4 5 6 7 8 9 10

How much have your symptoms interfered with your usual daily activities? (outside the home & housework)

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

In general, would you say your overall health right now is …

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Please list any other health care providers consulted for this condition.

____

Women: Are you or is there a possibility that you may be pregnant? ____________________________________

If yes, what is your due date? _________________________________

For Office use only:

DX Codes: _________ _________ _________ _________

Indicate if an *immediate* family member has / had any of the following:

___ Rheumatoid Arthritis ___ Heart Problems ___ Diabetes ___ Lupus ___ Stroke ___ Other ________________________

Please indicate if you have had or presently have any of the following conditions:

Cardiovascular

___ Fainting	___ Heart Disease	___ High/Low Blood Pressure	___ Irregular Heartbeat	___Phlebitis
___ Poor Circulation	___ Swelling of Hands/Feet	___Swelling of Legs	___Other: __________________________	

Ear/Nose/Throat

___ Dizziness	___ Hearing Loss	___Sinus Infection	___ Nose Bleed	___ Sore Throat
___ Jaw Clicks	___ Bleeding Gums	___ Difficulty Swallowing	___ Other __________________________	

Gastrointestinal

___ Nausea/Vomiting	___ Liver Problems	___ Constipation	___ Diarrhea	___ Ulcers
___ Black /Bloody Stools	___ Gallbladder Problems	___ Bowel Problems	___ Other __________________________	

Musculoskeletal

___ Osteoporosis	___ Arthritis	___ Joint Stiffness	___ Muscle Weakness	___ Gout
___ Broken Bones	___ Joints Replaced		___ Other__________________________	

Respiratory

___ Asthma	___ Bronchitis	___ Cold/Flu	___ Cough/Wheezing	___ Emphysema
___ Difficulty Breathing	___ Pneumonia	___ Shortness of Breath	___ Other __________________________	

Eyes

___ Glaucoma	___ Double Vision	___ Blurred Vision	___ Color Blindness	___ Cataracts
___ Glasses	___ Eye Pain	___ Poor Vision	___ Other __________________________	

Genitourinary

___ Kidney Disease	___ Burning Urination	___ Frequent Urination	___ Blood in Urine
___ Kidney Stone	___ Lower Side Pain		___ Other __________________________

Neurological

___ Stroke	___ Seizure	___ Severe Headaches	___ Numbness	___ Head Injury
___ Pinched Nerve	___ Carpal Tunnel	___ Brain Aneurysm	___ Other __________________________	

Hematologic/Lymphatic

___ Hepatitis	___ Blood Clots	___ Easy Bleeding	___ Easy Bruising	___ Cancer
___ Fever	___ Chills	___ Sweats	___ Other __________________________	

Endocrine/Constitutional

___ Diabetes	___ Thyroid Disorder	___ Menstrual Problems	___ Other __________________________
___ Weight Gain	___ Weight Loss	___ Difficulty Sleeping	___ Other __________________________

Surgeries/ Hospitalizations: ____

Serious Illness or Injury: ____

Allergies: ____

Medications taken within the last two months (include over the counter and vitamins): ________________________________

____

Habits: Caffeine (use/day) _________ Alcohol _________ Drugs (type/use/week) _________

Tobacco: Current Smoker (use/week): _____________ Former Smoker, quit date: __________ Never Smoked _____________

Are there any other issues concerning your health that you would like the doctor to be aware of? ____________________________________

____

Have you had any other significant traumas? (Auto Accidents, falls, etc.): ____

____

HIPPA PRIVACY AUTHORIZATION FORM

**** AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION****

I authorize Dr. Morgan Binnie at Snohomish Family Chiropractic to keep record and disclose my health information in necessary circumstances. Necessary circumstances would include:

- Disclosing your health information to another trusted healthcare provider in regards to verifying treatment and/or x-rays.
- Disclosing your healthcare information to another trusted healthcare provider in regards to referrals for continuing treatment.
- Disclosing your healthcare information and billing records to a trusted party if they become responsible of payment we can't obtain.
- Disclosing your healthcare information in the office with current employees for quality control and operational purposes.
- Disclosing your healthcare information to your insurance company.

Your right to limit use or disclosure

You have the right to request that we do not disclose any information to specific individuals, companies, organizations in legal parameters. If you would like us to place any restrictions on your health information, please provide us with a written and signed letter. We are not required to agree to your request if legal parameters are not met.

Your right to revoke your authorization

You may revoke your consent to us at any time in writing. We will not be able to honor your request if we receive it after your health information has already been sent for any of the reasons listed above.

I have read this policy agreement, asked for clarification if needed, and agree to these terms.

Printed Patient Name: _____________________________

Patient Signature: ________________________________ Date: __________________

Printed Guardian Name: ___________________________

Guardian Signature: _______________________________

OFFICE FINANCIAL POLICY

We are committed to providing exceptional chiropractic care for our patients and strive to make our services affordable for you. We are pleased to offer these payment options for you.

CASH / CHECK	VISA /MASTERCARD

Cash Patients

Payment is expected at time of service for any treatment provided, unless prior arrangements have been made and a payment plan arrangement has been signed. For your convenience, we accept cash, check, Visa, Mastercard and American Express.

***** For any questions about payments or payment plans, please do not hesitate to ask! We are here to help! *****

I agree that I have read the office financial policy for Snohomish Family Chiropractic and understand that I am fully responsible for any patient portion due to any matter listed above. I understand that any unpaid service is due within 90 days of service date.

Print Patient Name: ____________________ Print Guardian Name: _______________________

Patient Signature: _____________________ Guardian Signature: ________________________

Date: _____________________

Cancellation Policy/No Show Policy for Doctor Appointments

1. Cancellation/ No Show Policy for Doctor Appointment.

a) We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel, and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. If an appointment is not cancelled at least 12 hours in advance you will be charged a ten-dollar ($10) fee; we will use the credit card that you have on file with our office to automatically charge said fee.

b) If you fail to cancel or reschedule your appointments by the third (3rd) missed appointment with no cancellation 12 hours in advance you will be charged a twenty dollar ($20) fee; we will use the credit card that you have on file with our office to automatically charge said fee.

2. ***Scheduled Appointments***

We understand that delays can happen however we must try to keep the other patients and doctors on time. If a patient is 10 minutes past their scheduled time, we will have to reschedule the appointment.

___________________________	______________________________	____/____/____
Print Name Patient	Signature Patient/Guardian	Date

I hereby state that the information on this form is true and correct. I authorize Dr. Morgan Binnie to examine, take x-rays and treat for the care and management of my condition. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. We will release your health evaluation, and treatment records to you directly. Please notify office staff if you have any questions or concerns regarding this Office Policy Statement. If you are in agreement with this statement, please sign and date below.

___________________________	______________________________	____/____/____
Print Name Patient	Signature Patient/Guardian	Date