SNOHOMISH FAMILY CHIROPRACTIC

112 Avenue D, Suite A, Snohomish, WA 98290
Tel: (360) 863-2412 Email: SFChiro.office@gmail.com
www.snohomishfamilychiropractic.com

PATIENT INFORMATION

Name:_____

Address:_____City:_____

Zip: _____ Home/Cell Phone: _____

Email Address: _____

Birthdate: _____ Age: _____ Gender: ☐ Male ☐ Female

Pronoun: _____

Have you seen a chiropractor before? _____ If yes, when?_____

How were you referred to Snohomish Family Chiropractic? :

☐ Family Member ☐ Friend ☐ Doctor: _____

☐ Other: _____

In event of an Emergency

Name: _____ Relationship to Patient: _____

Phone #: _____ Work#: _____

I hereby state that the information on this form is true and correct. I authorize my doctor to examine, take x-rays and treat for the care and management of my condition in accordance with the state statutes. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that my doctor will prepare any necessary reports and forms to assist me in making collections forms to assists me in making collections from the insurance company and that any authorized to be paid, be paid directly to Snohomish Family Chiropractic, LLC which will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible to payment. I also understand that if I suspect or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I hereby authorize the release of my health evaluation, examination, prognosis, and treatment records to my employer, attorney, or insurance company. 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.

Patient Signature: _____ Date: _____

HIPPA PRIVACY AUTHORIZATION FORM

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

I authorize 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	HSA / 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, HAS, 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: _____

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SNOHOMISH
FAMILY
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Cancellation Policy/No Show Policy for Doctor Appointments

Our goal is to provide quality health care to all our patients in a timely manner. A cancellation made with less than a 24 hour notice significantly limits our ability to make the appointment available for another patient in need. Please be aware of our policy regarding missed appointments.

To remain consistent with our mission, we have instituted the following policy

1. If cancellation is necessary, we require that you call or text at least **24 HOURS** in advance. Appointments are in high demand, and your advanced notice will allow another patient access to that adjustment time.

2. Any appointments cancelled with less than 24-hours notice, “no show”, or late will be charged automatically with our Missed Appointment Fee using the card we have on file. Please note that our Fee Charge is **$50**.

3. If you are 10 or more minutes late for your appointment, the appointment may be cancelled and rescheduled with the fee applied.

4. As a courtesy, we make reminder texts for appointments one day in advance. Please note, if a reminder message is not received, the cancellation policy remains in effect.

5. Repeated missed appointments may result in termination of the doctor/patient relationship.

_____	_____	____/____/____
Print Name Patient	Signature Patient/Guardian	Date

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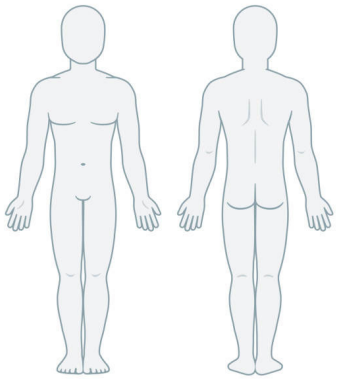
Please list the **symptoms** you're having/ describe what brings you in today:

_____
_____
_____
_____
_____
_____

Have you previously received care for any of the listed symptoms at another facility?

_____
_____
_____

Circle the areas in which you are experiencing **symptoms**:



Please answer the following more in-depth questions corresponding to each area of concern that brings you into our office:

Symptom 1 _____

Circle the words that describe the nature of this symptom:

Sharp Dull Throbbing Achiness Discomfort Headache Muscle Spasm
Numbness Stiffness Swelling Tender Tight Tingling Weak

When did you first notice this symptom? _____ What was the cause? _____

Rate the severity of this symptom **currently** (0-None, 10-Worst):

0 1 2 3 4 5 6 7 8 9 10

Rate the severity of this symptom **on average** (0-None, 10-Worst):

0 1 2 3 4 5 6 7 8 9 10

Circle how frequently you feel this symptom?

Occasionally (0-25%) Intermittently (26-50%) Frequently (51-75%) Constantly (76-100%)

When are your symptoms at their **worst**? Morning Midday Evening Night

Rate the severity of this symptom at its **worst** (0-None, 10-Worst): 0 1 2 3 4 5 6 7 8 9 10

Rate the severity of this symptom at its **best** (0-None, 10-Worst): 0 1 2 3 4 5 6 7 8 9 10

Circle what makes this symptom **worse**:

Driving Walking Working Bending Sports Sleeping Sitting Standing Twisting Lifting

Circle what makes this symptom **better**:

Rest Ice Heat Elevation Pain Meds Stretch Massage PT Chiropractic Acupuncture Movement

Symptom 2 _____

Circle the words that describe the nature of this symptom:

Sharp Dull Throbbing Achiness Discomfort Headache Muscle Spasm

Numbness Stiffness Swelling Tender Tight Tingling Weak

When did you first notice this symptom? _____ What was the cause? _____

Rate the severity of this symptom **currently** (0-None, 10-Worst):

0 1 2 3 4 5 6 7 8 9 10

Rate the severity of this symptom **on average** (0-None, 10-Worst):

0 1 2 3 4 5 6 7 8 9 10

Circle how frequently you feel this symptom?

Occasionally (0-25%) Intermittently (26-50%) Frequently (51-75%) Constantly (76-100%)

When are your symptoms at their **worst**? Morning Midday Evening Night

Rate the severity of this symptom at its **worst** (0-None, 10-Worst): 0 1 2 3 4 5 6 7 8 9 10

Rate the severity of this symptom at its **best** (0-None, 10-Worst): 0 1 2 3 4 5 6 7 8 9 10

Circle what makes this symptom **worse**:

Driving Walking Working Bending Sports Sleeping Sitting Standing Twisting Lifting

Circle what makes this symptom **better**:

Rest Ice Heat Elevation Pain Meds Stretch Massage PT Chiropractic Acupuncture Movement

Additional concerns or symptoms that bring you into our office:

_____

_____

_____

_____

Family History: Please specify if anyone in your family has any of these conditions and who:

Cancer? Family member _____

High blood pressure? Family member _____

Heart Attack? Family member _____

Diabetes? Family member _____

Stroke? Family member _____

Osteoarthritis? Family member _____

List any hospitalizations in the last 5 years: _____

List any medications or supplements you are currently taking: _____

_____

List any allergies you have: _____

_____

Please list any history of automobile accidents/ major trauma: _____

_____

Please list any surgeries you've had along with the date: _____

_____

Any possibility you may be pregnant?_____

Due date if so: _____

What is your occupation/ job title?

_____

Do you smoke or vape? _____

How many alcoholic drinks do you have on average? _____

How often do you exercise?_____

What type of exercise?_____

_____

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

- **Constitutional Symptoms:**
  __Chills __Fever __Weakness __Weight Loss/Gain
- **Eyes:**
  __Blurred Vision __Change in Vision __Glasses __Eye Pain
- **Ear/Nose/Throat/Mouth:**
  __Difficulty Hearing __Earaches __Ear Infection __Sinus Problem __Snore __Sore Throat
- **Cardiovascular:**
  __Chest Pain __Heart Murmur __High BP __Low BP __Irregular Heartbeat __Leg Swelling
- **Respiratory:**
  __Frequent Cough __Shortness of Breath __Wheezing
- **Gastrointestinal:**
  __Abdomen Pain __Constipation __Diarrhea __Heartburn __Nausea/ Vomiting __Ulcer
- **Genitourinary:**
  __Blood in Urine __Discharge __Painful Urination __Urinary Frequency
- **Musculoskeletal:**
  __Stiffness __Joint Pain __Balance Problems __Osteoporosis
- **Neurological:**
  __Dizzy __Headache __Balance Loss __Numb/ Tingling __Tremor __Ring in Ear __Seizures __Stroke
- **Endocrine:**
  __Diabetes T1 __Diabetes T2 __Thyroid Disorder __Heat/ Cold Intolerance
- **Hematological:**
  __Anemia __Blood Clot Problems __Easy Bruising __Swollen Glands