SNOHOMISH FAMILY CHIROPRACTIC

112 AVENUE D, SUITE A, SNOHOMISH, WA 98290

TEL: (360) 863-2412 EMAIL: DRMORGANBINNIE@GMAIL.COM

WWW.SNOHOMISHFAMILYCHIROPRACTIC.COM

PATIENT INFORMATION

Name: _____

Address:_____City:_____

Zip: _____ Home/Cell Phone: _____

Email Address: _____

Birthdate: _____ Age: _____ Gender: □ Male □ Female *Pronoun:_____

Occupation: _____ Employer: _____

How were you referred to Snohomish Family Chiropractic? :

□ Family Member □ Friend □ Doctor: _____

□ Other: _____

In event of an Emergency

Name: _____ Relationship to Patient: _____

Home Phone #: _____ Cell#: _____ Work#: _____

INSURANCE INFORMATION

Auto Accident ☐ Yes ☐ No Date of Accident: _____ Claim #: _____

Private Insurance: _____ Self Pay (not submitting to insurance)_____ Medicare:_____

Primary Insurance Company: _____

ID#: _____ Group#: _____ Phone#: _____

Address: _____

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 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 Dr. Morgan Binnie 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: _____

Briefly describe your current symptoms? _____

_____

When did your symptoms start? _____

_____

Is your current injury/condition related to an auto/ work accident? ☐ Yes ☐ No

If yes, what is the date of accident? _____

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%)

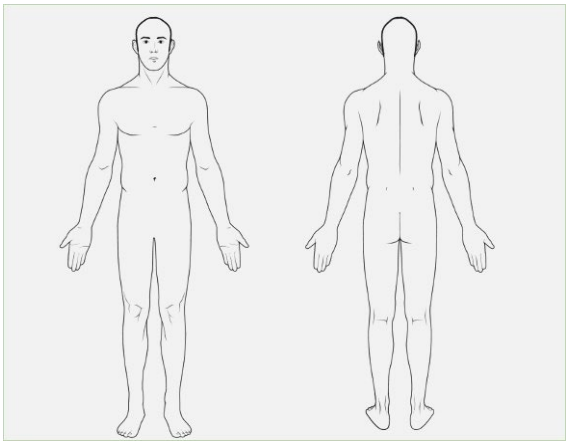
If anything, what makes this better? _____

_____

If anything, what makes this worse?_____

_____

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



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

How is your condition changing, since care began at this facility?

☐ N/A – this is the initial visit ☐ Much Worse ☐ Worse ☐ A little worse

☐ No Change ☐ A little better ☐ Better ☐ Much Better

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.

_____

Past Chiropractic Care? ☐ Yes ☐ No Dr. Name/Location: _____

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: _____ _____ _____ _____

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Please indicate if you have 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 _____

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

___ Rheumatoid Arthritis ___ Heart Problems ___ Diabetes ___ Lupus ___ Stroke ___ 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.): _____

_____

_____ Patient Initials

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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	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.

Insurance patients

As a courtesy to you, we will file your insurance claim on your behalf after every appointment. We will do our best to estimate what your patient portion will be after insurance has paid if needed. For any amount that is left after insurance has paid, regardless of the estimate, will be patient portion and responsibility to provide payment.

***** 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; this will not be covered by your insurance company and 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; this will not be covered by your insurance company and 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 15 minutes past their scheduled time, we will have to reschedule the appointment.

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

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