Acct # _____

Name_____ DOB _____/_____/_____
(last, first)

Sex M F Marital Status M S W D Children_____ SSN_____

Address_____ City_____ Zip_____

Email_____ Phone#_____

Occupation_____Employer_____

Primary Care Physician_____ Phone#_____
May we contact your Primary Care Physician regarding your care ☐ Yes ☐ No

Referred by_____

Date	Plan	Assessment	Objective	DC initials

Precision Chiropractic and Massage

	Date	Emp
Card		
NPO Scheduled		
Day 2		
PCP		
Ref		
Re Exam		

Major Complaints

A) _____ D) _____

_____ _____

B) _____ E) _____

_____ _____

C) _____ F) _____

_____ _____

Medications

_____

_____

Which of your major complaints bother you the most A B C D E F

How long have you had this complaint(s) _____

_____

_____

Prior to the problem beginning, did you ever have an earlier problem that was the same or similar? ____

_____

_____

Did it appear ☐ Slowly ☐ Immediately

Does anyone else in your family have this problem or a similar one? _____

_____

How often does it bother you now? _____

When it is at its worst, how does it feel? _____

When it is at its worst, how does it interfere with your normal daily activities? _____

_____

How does this problem reduce your productivity at work? _____

_____

How does it create any problems in your relationship?_____

_____

What have you done to aggravate the problem and/or what have you failed to do that would have helped get rid of it? _____

_____

If your problem was left unhandled for five years, how do you think it would affect you? _____

_____

Are you committed to getting rid of not only the symptoms but what has caused it, even if it requires a change in your life-style? ☐Yes ☐No

Precision Chiropractic

460 228th Ave NE, Sammamish, WA 98074

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Precision Chiropractic, we may use or disclose personal and health related information about you in the following ways:

*Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment, or treatment.
*Your healthcare records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer; they may be responsible for the payment of services provided to you.
*Your name, address, phone number, and your healthcare records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine, or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

You have a right to request restrictions on our use of your protected health information for treatment, payment, and operations purposes. Such requests are not automatic and require the agreement of this office.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

*If we provide healthcare services to you in an emergency.
*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
*If there are substantial barriers to communicating with you, but in our professional judgement we believe that you intend for us to provide care.
*If we are ordered by the courts or another appropriate agency.

You have a right to receive an accounting of any such disclosures made by this office. Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your healthcare if you would like to receive this information at an address other than your home, or if you would like the information in a specific form, please advise us in writing as to your preferences.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to Dr. Brandon Velasco.

If you would like further information about our privacy policies and practices please contact Dr. Brandon Velasco.

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary, your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.

This office utilizes a "semi open-adjusting" environment for ongoing patient care. "Semi open-adjusting" involves patients being seen in adjusting rooms without doors. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and this is NOT the environment used for taking patient histories, providing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in a semi open-adjusting environment other arrangements will be made for you.

This notice is effective as of _____/_____/_____. This notice, and any alterations or amendments made hereto will expire six years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Patient Name (Printed)	Signature	Date

If you are a minor or if you are being represented by another party

Personal Representative (Printed)	Personal Representative Signature	Date

Description of the authority to act on behalf of the patient

_____

Please check below:

- ☐ I, the patient, authorize Precision Chiropractic & Massage and consent to the release of sensitive private medical information to or discuss my care, as articulated under Washington State Law, to who is listed below. (Example: spouse, child, family physician, power-of-attorney, caretaker, family member, etc.) This authorization will be in effect until revoked, in writing, by me.
- ☐ I, the patient, do not authorize or consent to the release of routine medical information.

Patient Name (Printed)	Patient Signature	Date

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. 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.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who is specialized in the area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

_____ _____
Signature of Patient/ Guardian Date

ATTENTION FEMALES

This is to certify that to the best of my knowledge I am not pregnant and the Doctor and his/ her associates have my permission to perform any necessary x-rays. I have been advised that x-rays can be hazardous to an unborn child.

Date of Last Menstrual Period: _____

_____ _____
Signature of Patient/ Guardian Date

Precision Chiropractic Fee Schedule/Agreement

Consultation	No Charge
Chiropractic Examination	$91-$334
X-Ray Studies (2 per frames)	$67-$500
Chiropractic Adjustment	$62-$97
Rehab services (traction, exercises)	$49-$60

Plan #1 – Insurance: If you have Insurance that covers Chiropractic Care, we will verify your insurance benefits and bill your insurance directly as a service to you. Most patients have a deductible and a copay to meet and certain services may not be covered under the terms of your Health Insurance Plan.

Plan #2 – Cash: Fees are to be paid at the time services are rendered unless special arrangements have been made in advance. Please consult with the Assistant if special arrangements are needed.

Plan #3 – Work Injury: *Please see Assistant for proper forms.*

Plan #4 - Automobile Accident: *Please see Assistant for proper forms.*

All patients, with or without insurance, are responsible for payment on the first visit (unless other arrangements have been made in advance).
Interest on unpaid balances will accrue at 1% per month.
We accept: Cash, Check, Debit, Visa, MasterCard, and Amex.

Agreement: My signature below signifies that this information is true and correct to the best of my knowledge. I acknowledge that it is my responsibility to know and understand my insurance policy coverage and its benefits. I understand and accept that I am responsible to pay for all charges incurred at this office. All fees are payable at the time services are rendered unless other arrangements have been made in advance. I agree to make financial arrangements for any services not covered by my insurance, including but not limited to, any deductibles, co-payments, or co-insurance. I hereby authorize Precision Chiropractic to release to my insurance carrier and its agents any information required for my claim and for my insurance carrier to pay Precision Chiropractic directly.

I have read and fully understand and agree to the above statements.
I qualify for plan #: **1 2 3 4** (circle one)

Signature:_____ **Date:** _____

Witness: _____ **Date:** _____