

Patient Profile

Name _____ Birth Date _____

How you like to be addressed, if different from above _____

Address _____ City _____ State _____ Zip _____

Social Security # _____ - _____ - _____ E-Mail Address _____

Home # () _____ Work # () _____ Cell # () _____

Occupation _____ Employer _____

Male / Female _____ Number of Children _____ Names of Children _____

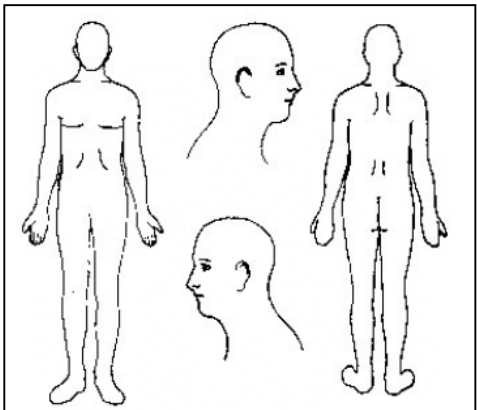
Single __ Married __ Divorced __ Widowed __ Name of Spouse/Partner _____

Height ____' ____" Weight _____ lbs How did you hear about us? _____

Main reason for consulting our office today? _____

****Please check if you are here for any of the following: Car Accident _____ Work Injury _____ Other Injury _____**

Please mark your areas of pain below



- | | | |
|---|--|--|
| <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Sore Muscles | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Shoulder Problems | <input type="checkbox"/> Walking Problems | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Numbness in Arms | <input type="checkbox"/> Muscle Cramps | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Weak Muscles | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Low Back Problems | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Poor Digestion |
| <input type="checkbox"/> Leg Problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Numbness in Legs | <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Loss of Feeling | <input type="checkbox"/> Depression | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Stiff Joints | <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Kidney Infection |
| <input type="checkbox"/> Painful Joints | <input type="checkbox"/> Ear Pain/Noises | <input type="checkbox"/> Menstrual Cramps |
| <input type="checkbox"/> Restricts Daily Activities | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Restricts Daily Exercise | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Blood Pressure-
High/Low |
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Tiredness/Fatigue | |
| <input type="checkbox"/> Mid Back Problems | <input type="checkbox"/> Headaches | |

Which of the above symptoms is the worst? (List up to three if necessary) _____

On a scale of 1-10 (1 being very little pain and 10 extreme pain) how would you rate the worst symptom? _____

This is a new/old condition. It was not/was treated before.
If treated before, what was done? _____

Name of Doctors _____

Have you ever had surgery or been hospitalized? _____

List Surgeries _____

Have you ever had chiropractic care before? _____

Name of Doctor _____

Last time you had x-rays _____

Medications/Over-the-counter drugs _____

From birth to present, please list and describe:

1) Car Accidents _____

2) Falls/Injuries _____

3) Sports Injuries _____

4) Other _____

Office Fee Schedule and Financial Policy

<u>Service</u>	<u>At Time of Service</u> (Patients without insurance benefits)	<u>Standard Fee</u>
Initial Assessment	\$75.00	\$163.00 - \$250.00
Report of Findings	N/C	\$160.00
Dynamic Assessment	\$43.00	\$65.00 - \$105.00
Adjustment	\$30.00 - \$50.00	\$44.00 - \$80.00
Extremity Adjustment	\$40.00	\$40.00
Manual Traction (15 Minutes)	\$44.00	\$44.00

Financial Policy and Chiropractic Active Life Plans

We are committed to providing you with the highest quality chiropractic care possible in a warm, caring environment. Our financial policies have been established to achieve that goal. You will be expected to pay for your first visit at the time the service is rendered unless insurance benefits have been confirmed, or you have arranged an Active Life Plan in advance. Active Life Plans include yearly Corrective Adjustment Plans (CAP), and monthly CAP plans. These Active Life Plans are designed to be the most cost effective way to keep you and your family as healthy as possible. Details of these plans will be discussed with you during your Chiropractic Report.

Medical Insurance: If you have medical insurance that has chiropractic benefits, we will bill your insurance if you so choose. However, you may choose to opt out at any point and we will stop billing your insurance; if you decide to opt out, be aware that you will be responsible for the full at time of service fees. We, as the provider, also reserve the right to refuse to bill your insurance carrier for any reason (excluding Medicare). If/ when that time comes you will be told about our decision in advance and in writing.

We ask that you leave a credit card number on file in the event of any outstanding deductible or copay/coinsurance charges.

Visa Mastercard American Express Discover

Card Number _____ Exp. _____

We review and evaluate our rates annually, and reserve the right to change fees.

I have read and I understand the above policies.

Patient Signature _____ Date _____

PROPERTY OF:
Vitality Chiropractic
(206) 824-5521

21904 Marine View Drive S
Des Moines, WA 98198

Terms of Acceptance

When an individual or family seeks, and is accepted for, chiropractic care, it is essential for all parties to be working toward the same objective.

Chiropractic has only one goal. It is important that everyone understands both the objective, and the method that will be used to achieve it. This will prevent any confusion or disappointment.

Definitions:

Health: A dynamic state of wholeness in which your body can accurately perceive its constantly changing needs and respond appropriately in a timely manner. In short, *Health is the ability to adapt* to both internal and external stresses, whether they are physical, chemical, or emotional.

Subluxation: A disruption in the normal flow of neurological impulses that the nerves carry between the brain and all the cells of the body. This causes an alteration of the normal physiology and leads to a state of "dis-ease" (the inability of the body to adapt).

Chiropractic Adjustment: The specific application of proven gentle force techniques to facilitate the body's correction of subluxation and restore its innate healing processes so as to progressively bring about a state of health and wholeness.

We do not offer to diagnose or treat any disease or condition other than subluxation. However, if during the course of your chiropractic assessment, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will be more than happy to refer you to the appropriate health care provider who specializes in that 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 symptoms resulting from subluxation. The only method used to accomplish this is the use of the specific chiropractic adjustment to correct the subluxation process.

I, _____, have read and understand the above.
(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 for myself and on behalf of my family on this basis.

Signed _____ Date ___/___/___

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Personal Health Records Privacy/ Access Policy

Privacy: We will protect your personal health information against disclosure to unauthorized entities/ persons. With your permission we will share your personal health information only with entities/ persons directly related to your health care and insurance/ payment needs. We will ask for your written permission for any other disclosure of your personal health information.

Access: You have the right to review and amend your personal health care records. Fees for copying your personal health information/ records are set by state regulators annually.

Consent: Yes _____ I authorize or No _____ I do not authorize, Vitality Chiropractic to share my personal health information with all entities/ persons directly related to my health care and my insurance/ payment needs.

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. Bonnie Verhunce at (206) 824-5521.

If you would like further information about our privacy policies and practices please contact Dr. Bonnie Verhunce at (206) 824-5521.

This notice is effective as of April 14, 2003. This notice and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____	_____	_____
Name (printed)	Signature	Date

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

_____	_____	_____
Personal Rep. (printed)	Personal Rep. Signature	Date

Description of the authority to act on behalf of the patient.

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Legal Assignment of Benefits and Health Insurance Disclosure Agreement

I, the undersigned patient, affirm that I do have insurance and/ or employee medical benefit coverage with an insurance carrier, and I understand and acknowledge that Vitality Chiropractic will bill my insurance carrier for the medical expenses to be incurred while I'm in treatment. Any and all insurance payments and/or insurance reimbursement will be made payable to Vitality Chiropractic by the carrier. If at any time my insurance carrier makes a payment for my care directly to me (instead of Vitality Chiropractic), I agree to honestly and fully pay Vitality Chiropractic for the services rendered. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments or coverage.

I authorize any plan administrator or fiduciary, insurer, and/ or my attorney to release any and all plan documents, insurance policy and/or settlement information to Vitality Chiropractic upon written request. I authorize the use of this signature on all my insurance and/or employee medical benefits claim submissions.

I, the patient, understand that a certain portion of my care may not be covered by or has not been authorized by my insurance plan. I acknowledge that if any portion of the care provided is not, or may not be, covered by insurance, then I will be responsible for payment, and I will make the necessary financial arrangements with my healthcare provider to pay for these services. I understand that Vitality Chiropractic will make every legal effort to receive payment from the carrier for medically necessary chiropractic treatments and I agree to cooperate with my health care provider in any/ all of these attempts, including, if necessary, bringing suit with my insurance carrier at the cost of my provider.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature of Insured/Guardian

Date

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