Your Life Review *Fox Chiropractic Wellness Center*

Welcome to our Office

Name:_____ **Home:** _____ ***Cell:** _____
Work:_____ **Fax #:** _____ **E-Mail:** _____
Address:_____**City:**_____**State:**_____
Zip:_____ **Age:**____ **DOB:**____ ____ ____ **Occupation:**_____
Who can we thank for your referral: _____

Ins. Name:_____ **Ins. ID#:**_____
Secondary Ins. Name: _____ **Ins. ID#** _____
Do you have a Health savings account/Flex payment program? yes ☐ no ☐ Are you Pregnant: yes ☐ no ☐

Give a brief detailed description of the problem you are currently experiencing:

_____
_____
_____
_____

How long have you had this condition? _____**is it getting worse?** _____
Does it affect your (check appropriate boxes): ☐ work, ☐ sleep, ☐ other**:** _____
Treatment received in the past? _____ Pain level at its worst? (0-10) _____

Please check all your warning signs even if not seemingly related to your complaint.

☐ frequent colds ☐ anxiety	☐ diabetes	☐ bed wetting	☐ Ringing in Ears
☐ cold hands/feet ☐ ulcers	☐ incontinence	☐ mood swings	☐ Breathing problems
☐ bowel problems	☐ poor awakening	☐ panic attacks	☐ Shoulder pain
☐ constipation	☐ low pain threshold	☐ fevers ☐ fatigue	☐ Elbow pain
☐ diarrhea	☐ headaches ☐ seizures	☐ MS ☐ Vertigo	☐ Wrist/Hand pain
☐ high BP ☐ tight muscles	☐ narcolepsy ☐ PMS	☐ Epstein-Barr syndrome	☐ Hip pain
☐ heart palpitations	☐ sleep walking	☐ Fibromyalgia	☐ Knee pain
☐ ADD	☐ hot flashes	☐ depression	☐ Ankle/Foot pain
☐ low energy	☐ allergies	☐ Rheumatoid arthritis	☐ Auto-immune system disorders
☐ sinusitis	☐ IBS	☐ Chronic fatigue synd.	☐ Balance issues
☐ arm/ leg weakness	☐ eating disorders	☐ TMJ (Jaw Pain)	

List current medications:

_____
_____

List of injuries: (ex: falls, sports injuries, repetitive stress injuries)

1. _____
2. _____
3. _____
4. _____
5. _____

Ever been in any motor vehicle accidents? (please note type and year, even if not apparently injured)

_____
Any surgeries?_____
Have you received Chiropractic care before? yes ☐ no ☐
If yes, Name of Chiropractor-Dr:_____ **,Location:**_____
Have you received acupuncture care before? yes ☐ no ☐ If yes, list location: _____
Have you seen a massage therapist before? yes ☐ no ☐ If yes, list location: _____

Name of Medical Provider-Dr: _____**, Location:** _____

Agreements

The statements made on this form are accurate, to the best of my recollection, and I agree to allow this office to do an examination of me for further evaluation.

SIGNATURE_____ **DATE**_____

Office Use Only
O2:_____
P:_____
Ht:

Fox Chiropractic Wellness Center

List current over the counter medications and nutritional supplements

_____

_____

_____

_____

_____

FAMILY MEDICAL HISTORY

F=Father M=Mother H=Husband W=Wife K=Kid(s) S=Sibling G=Grandparent

Place the appropriate letter(s) in the blank of someone in your family has/had any of the following:

_____ **Allergies** (Hay fever, Food Allergies, etc.)

_____ **Anxiety**

_____ **Arthritis/Joint Disease**

_____ **Asthma/Breathing Problems**

_____ **Bed Wetting**

_____ **Bursitis** (Shoulder, Hip, etc)

_____ **Cancer** - type?_____

_____ **Carpal Tunnel Syndrome**

_____ **Depression**

_____ **Diabetes** - type?_____

_____ **Digestive Disorder** (GERD/Refiux, Ulcers, IBS, Crohn's, etc)

_____ **Ear Infections** (repeated/chronic)

_____ **Fatigue/Low Energy**

_____ **Fibromyalgia**

_____ **Foot/Ankle Pain**

_____ **Headaches** (Migraines, Tension, etc)

_____ **High Blood Pressure**

_____ **High Cholesterol**

_____ **Knee Pain**

_____ **Lower Back Pain**

_____ **Neck Pain**

_____ **Numbness/Tingling**

_____ **Osteoporosis**

_____ **Plantar Fasciitis**

_____ **Sciatic Pain/Sciatica**

_____ **Shoulder Pain**

_____ **TMJ/Jaw Pain**

_____ **Upper Back Pain**

Please check any of the following services you would like more information about:

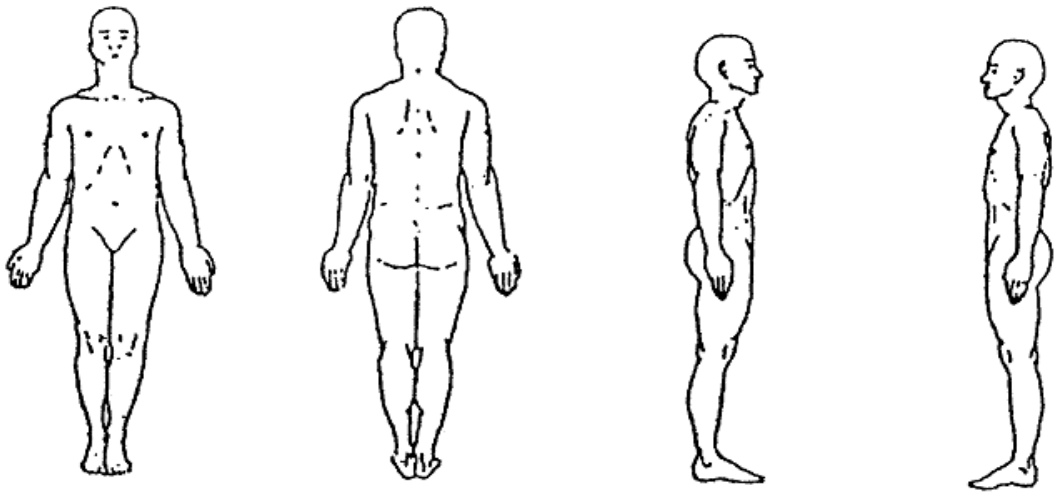
❑ Medical Weight Loss ❑ Acupuncture ❑ Massage

❑ Knee Regeneration Therapy ❑ Decompression Disc Therapy ❑ Chiropractic

Joint/Pain Evaluation Chart & Questionnaire

Name: _____ Date: _____

Primary Onset (check one) □ Chronic issue, □ Sports injury, □ Car accident, □ Work injury



Front **Back** **Right** **Left**

Indicate the location of pain/ discomfort above. Use the symbol that best describes the feelings:

XXX sharp/ stabbing **PPP** pins/needles **DDD** dull/aching **NNN** numbness

□ **Leg pain –** numbness / tingling □ **Arm pain –** numbness / tingling □ **Weakness –** numbness / tingling

Daily living Questionnaire

What type of work do you do? _____Hours per day? _____
Hours per day prior to pain/discomfort? _____
How is your work affected? _____

Home & Family list the activities affected by your exacerbation:
_____

Sleep: How many hours of sleep per night do you sleep now? _____ prior _____
Do you feel your sleep is affected? If yes, explain briefly
_____

Social/Recreational: Activities _____
How are your current activities affected? _____
_____

_____ _____
Signature Date

Fox Chiropractic Wellness Center

FINANCIAL POLICIES AND AGREEMENTS

Because clarity about financial matters is essential for you to receive optimum benefit from your care, we have outlined our financial policies and agreements below. Please read carefully and sign or initial where indicated.

I, _____, understand and agree to the following:

(Print your name)

A. **I am solely responsible for the expenses of my care and/or the care of my dependents. While I may assign payment of benefits to Fox Chiropractic Wellness Center (FCWC), any uncovered services, deductibles, and co-payments are my financial obligation, to the extent allowed by the terms of the FCWC's provider contracts with insurance plans.** *(While most insurance plans cover chiropractic, massage, acupuncture, medical, naturopathic medicine your health and accident policies are a contract between you and your insurance company. We are happy to prepare any necessary reports and forms to assist you in making collection from your insurance company. See our Fee Schedule for current fees. Prices are subject to change.)*

B. **INSURANCE NON-COVERED SERVICE DISCLOSURE AND AGREEMENT**

1. **Potential reasons for non-covered status include: The service is or may be deemed (a) investigational or experimental under the carrier's internal guidelines; (b) not medically necessary under the carrier's internal care or cost management guidelines; (c) not actually covered under the plan to which you are subscribed; (d) not provided in accordance with the Provider's Agreement with the carrier or other requirements of the carrier's or managed care entity's internal guidelines.**
2. **The carrier authorizes the provider to charge the patient for the above services so long as this disclosure is made and signed by the patient prior to the services being provided.**
3. **I acknowledge that the Non-Covered status of the proposed service(s) has been explained and that a certain portion of my care may not be covered by or has not been authorized by my insurance plan. If any portion of the care provided is not, or may not be covered by insurance, then I shall be responsible for payment and shall make the necessary financial arrangement with the healthcare provider to pay for these services. _____**
   (Initial)

C. **ASSIGNMENT AND GROUP ACCIDENT AND HEALTH INSURANCE:** *See attached form*. Any amount authorized to be paid directly to Fox Chiropractic Wellness will be credited to your account upon receipt.

D. **CHOICE OF PAYMENT OPTIONS:** We are happy to provide the following payment options. If you are choosing to use your insurance, you will need to pick a second option for any services not covered by your insurance.

1. **Insurance Coverage: coverage varies with individual plans;** generally, only a portion of the recommended care plan will be covered.
2. **Cash/Credit Per Visit:** includes money orders, personal checks, credit and debit cards; generally a 20% discount applies.
3. **Payment Plans: monthly or yearly payment plans are available with an approximate savings of 20-25%. Care Credit Card:** A zero-or-low-interest health care credit card which you may apply for and use here in our office upon your request.

Please circle your two choices above and initial here _____

E. AUTHORIZATION FOR TAKING AND RETAINING X-RAY FILMS: I hereby authorize the taking of analytical x-ray films by the doctors, clinic, and/or staff of Fox Chiropractic Wellness, of such areas as may be of anatomical interest and which may be recommended from time to time by the doctor(s). Further, I agree that the doctor(s)/clinic shall be the sole owner of such analytical films and shall remain in custody and in control of said films, until such time as I shall sign a Release Form stating otherwise. Such form will be provided by Fox Chiropractic Wellness Center, P.S., upon request. (See signature below and initials here: _____.)]

**** Females only: I state that I am not pregnant. (See signature below and initials here: _____.)**

_____ _____

Patient (or Parent/Guardian) Signature **Date**

_____ _____

Fox Chiropractic Wellness Signature **Date**

Fox Chiropractic Wellness Center

Consent for Care

(Please read, initial & sign below)

I, _____(the patient or guardian), **grant permission to Fox Chiropractic Wellness Center to perform examinations and procedures as may be professionally deemed necessary or advisable for me as patient this may include one or more of the following:**

Chiropractic adjustment: this specific application of forces to facilitate the body's correction of vertebral subluxation. Vertebral subluxation is the misalignment of nerve impulses, resulting in lessening of the body's innate ability to achieve its maximum health.

Acupuncture: a technique of oriental medicine that includes the insertion of fine, sterile needles at specific points along the body. Acupuncture meridians or channels are pathways through which the body's vital energy flows throughout the body. The points lie along the meridians and provide gateways to influence, redirect, increase or decrease the body's vital substance (qi and blood) thus correcting many of the body's imbalances.

Massage: massage techniques manipulate the muscles of the body increasing your range of motion and eliminates the body of any toxic waste. It aids in stress relief, increases circulation, and releases endorphins which enhances pain relief.

*If pregnant, please talk to the front desk about your prenatal massage.

Rehab Therapy: This may include rehabilitative exercises; home care stretches; Laser Therapy and will be performed by trained team members at Fox Chiropractic Wellness.

Cryotherapy Weight loss : a process called cryolipolysis which uses a rapid decrease in temperature to kill fat cells.

I do not expect the doctor(s) or licensed practitioner(s) to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor(s) or licensed practitioner(s) to exercise judgment during the course of treatment which the doctor/practitioner feels at the time, based upon the facts then known to him or her, is in my best interest. _____ (initial)

I have read the explanation above of the treatments/ services offered at Fox Chiropractic Wellness, I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing care and treatment. I have freely decided to undergo the recommended care and treatment, and herby give my full consent to care and treatment here. _____ (initial)

_____	_____	_____
Patient/ Responsible party signature	Printed Name	Date
_____	_____	_____
Fox Chiropractic Wellness Staff	Printed Name	Date

Fox Chiropractic Wellness Center

Privacy Practices & HIPPA Disclosure

I consent to the use or disclosure of my protected health information by Fox Chiropractic Wellness for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Fox Chiropractic Wellness. I understand that diagnosis or treatment of me by the treating provider may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Fox Chiropractic Wellness is not required to agree to the restrictions that I may request. However, if Fox Chiropractic Wellness agrees to a restriction that I request, the restriction is binding on Fox Chiropractic Wellness.
I have the right to revoke this consent, in writing, at any time, except to the extent that Fox Chiropractic Wellness has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identities me, or there is a reasonable basis to believe the information may identify me. I understand I have the right to review Fox Chiropractic Wellness's Notice of Privacy Practices prior to signing this document.

Fox Chiropractic Wellness' Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices describes the type of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Fox Chiropractic Wellness.

The Notice of Privacy Practices for all treating providers is also provided at the front desk of Fox Chiropractic Wellness.

This Notice of Privacy Practices also describes my rights and the duties of Fox Chiropractic Wellness with respect to my protected health information.

Fox Chiropractic Wellness reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

HIPAA Discloser

I authorize the following people access to my protected health information:

Name_____ Relationship: _____

Name_____ Relationship: _____

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

Description of Personal Representative's Authority

Massage/Acupuncture Appointment Policy

Regrettably, due to the excessive amount of repeat **NO SHOWS** and **LAST-MINUTE CANCELATIONS (within 24 hrs)** we will be charging a $**25.00** FEE.

We respectfully ask that if you are unable to make it to your appointment as scheduled, **please cancel at least 24 hours prior to the start of your appointment time. We also text to confirm appointments. If you do not confirm by text we will call to confirm. If your appointment is left unconfirmed it is subject to being canceled.**

You can cancel your appointment time by calling our office.

253-851-5138

However, if we *are able to fill the time slot*, then there will be NO FEE ☺. So, the sooner you notify us that you're unable to make your appointment, the better chance we're able to fill the time slot.

To enforce this policy, we will be saving a credit card on file. By signing this notice, you are agreeing to the policies above.

Thank you for your understanding,
Your Fox Chiropractic Wellness Team

_____ _____

Patient's signature Date

_____

Printed Name