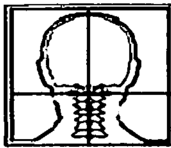


Atlas Spinal Care

16500 SE 15th Street, Suite 160
Vancouver, WA 98683
(360) 718-7944 FAX (360) 718-7931

PATIENT INFORMATION

Name:______________________________________

Address:____________________________________

____

Birth Date: ___/___/___ Age: ____ Male ☐ Female ☐

Social Sec #: ___/___/___

Occupation_________________________________

Employer: _________________________________

Marital Status:______________ # Children: _________

INSURANCE

Who is responsible for this account?________________

Relationship to patient? ___________________________

Primary Insurance Company: ________________________

Policy #: ________________Group #: _______________

Primary Policy Holder:_______________ DOB __________

Secondary Insurance Company: ______________________

Insurance ID #: ________________Group #: __________

Primary Policy Holder: _______________ DOB _________

CONTACT INFORMATION

Home #: _______________ *Wk #:* _______________

Cell #: ______________ *Email:* ________________

Best way to reach you: Home ☐ *Cell* ☐ *Wk* ☐ *Email* ☐

EMERGENCY CONTACT:

Name: _________________ *Relationship:* __________

Home Phone: ______________ *Cell#:* _____________

Who may we thank for referring you?

____

ACCIDENT INFORMATION

Is your condition due to an accident? No ☐ Yes ☐

Date of Accident: ___/___/___

Type? Auto ☐ Work ☐ Other _________________

To Whom have you reported the accident?

Insurance ☐ Worker's Comp ☐ Employer ☐

Insurance Company: _____________________________

Claim #: ______________________________________

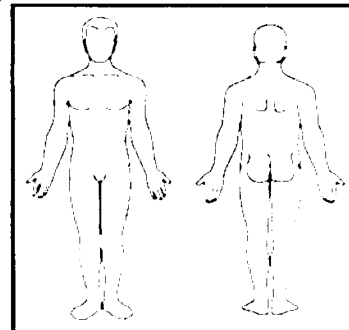
Claim Adjuster: _______________ Phone #: ___________

Attorney's Name (if applicable) ____________________

Attorney's Phone # ______________________________

PATIENT CONDITION

Please mark where it hurts



Chief complaint or reason for your visit today? ____________________________

When did your symptoms begin? ____________________________

*Have you had this problem before?*____________________________

Is your condition getting progressively worse? *Yes* ☐ *No* ☐

Is this problem: *Constant* ☐ *Comes & Goes* ☐

How does it feel? *Burning* ☐ *Sharp* ☐ *Shooting* ☐ *Dull* ☐ *Ache* ☐

Stiff ☐ *Tingling* ☐ *Throbbing* ☐ *Swelling* ☐ *Other* ____________

Circle the severity of your pain ***(no pain)*** *0 1 2 3 4 5 6 7 8 9 10* ***(severe pain)***

What makes your condition better? ________________ *What make your condition worse?*____________________

Does it interfere with your: *Work* ☐ *Sleep* ☐ *Daily routine* ☐ *Recreation* ☐

Activities/movements that are painful to perform: *Sitting* ☐ *Standing* ☐ *Walking* ☐ *Bending* ☐ *Lying down* ☐ *Driving* ☐ *Reading* ☐

HEALTH HISTORY

WHAT OTHER TREATMENTS HAVE YOU HAD FOR THIS CONDITION? CHIROPRACTIC ☐ ORTHOPEDIC ☐ NEUROLOGIST ☐ PHYSICAL THERAPY ☐ MEDICATION ☐ SURGERY ☐

NAME OF THE DOCTOR(S) WHO HAVE TREATED YOU FOR THIS CONDITION? ______________________

DESCRIBE THE OTHER DOCTOR'S TREATMENT FOR YOUR CONDITION: ______________________

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? NO ☐ YES ☐ IF SO, WHEN ______________

DATE OF LAST: PHYSICAL EXAM ________ SPINAL X-RAY ________ MRI ________ CT SCAN ________

LIST ANY ALLERGIES YOU CURRENTLY HAVE: ______________________

LIST ANY MEDICATIONS YOU ARE TAKING: ______________________

LIST ANY VITAMINS/HERBS/MINERALS YOU ARE TAKING: ______________________

PREVIOUS SURGERIES AND DATES: ______________________

BROKEN BONES AND DATES: ______________________

FALLS/ INJURIES AND DATES: ______________________

FEMALE PATIENTS: ARE YOU PREGNANT? YES ☐ NO ☐ BEGINNING OF LAST MENSTRUAL CYCLE _____ REGULAR/IRREGULAR?

CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE HAD:

- ☐ EARACHE
- ☐ EPILEPSY/SEIZURES
- ☐ ANXIETY/DEPRESSION
- ☐ ARM/SHOULDER PAIN
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ BLADDER PROBLEMS
- ☐ CANCER
- ☐ CHRONIC FATIGUE
- ☐ DEAFNESS
- ☐ DIABETES
- ☐ DIGESTION PROBLEMS
- ☐ EAR RINGING
- ☐ HIGH BLOOD PRESSURE
- ☐ HEADACHES/MIGRAINES
- ☐ HEART DISEASE
- ☐ HEPATITIS
- ☐ HERNIATED DISK
- ☐ INSOMNIA
- ☐ KIDNEY PROBLEMS
- ☐ LEG PAIN
- ☐ LOW BACK PAIN
- ☐ MID BACK PAIN
- ☐ NECK PAIN
- ☐ OSTEOPOROSIS
- ☐ POOR CIRCULATION
- ☐ PROSTATE PROBLEMS
- ☐ RHEUMATOID ARTHRITIS
- ☐ SCIATICA
- ☐ SCOLIOSIS
- ☐ SHINGLES
- ☐ SINUS INFECTION
- ☐ STROKE
- ☐ THYROID PROBLEMS
- ☐ TMJ
- ☐ VERTIGO/ DIZZINESS

STRESSORS :

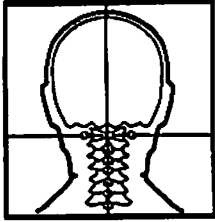
- ☐ SMOKING — PACKS/DAY ________
- ☐ ALCOHOL — DRINKS/WEEK ________
- ☐ COFFEE/CAFFEINE DRINKS — CUPS/DAY ________
- ☐ HIGH STRESS LEVEL — REASON ______________

EXERCISE:

- ☐ NONE
- ☐ MODERATE
- ☐ HEAVY

DAYS PER WEEK ________

PATIENT SIGNATURE: ______________________ DATE: ______________________



Atlas Spinal Care, P.C.

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Fax: (360) 718 - 7931

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays and/or other tests on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

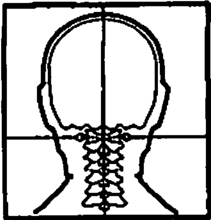
I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office of clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, falls, dizziness, headaches, burns with modalities and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature X______________________________ Date: ___________

(Or Patient Representative) (Indicate relationship if signing for patient)



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Financial Policy

Missed Appointments

- Appointments not rescheduled with a 24-hour notice will be subject to a ***$25*** fee.

Self-Payment

- If you are a self-paying patient, payment is expected at the time of service.
- A time of service discount is offered to all chiropractic patients if payment is received on the same day of service; if not, regular fees will be applied.
- There will be a ***$25*** charge for all returned checks.

Health Insurance

- If insurance coverage is verified, we will bill for services, but co-payment is expected at the time of service. You are responsible for any unpaid balance by your insurance company.

Workers Compensation Claims

- All worker's compensation cases will be billed directly to the insurance company, provided the appropriate paperwork has been filled out and a claim has been filed. If the claim is denied, we will bill your private insurance carrier if you have coverage. Please keep in mind that if your claim is denied, you are responsible for prompt payment of your account.

Personal Injury/Motor Vehicle Accidents

- Personal injury and auto accident cases will be billed to your insurance company, providing that a claim has been filed and the appropriate paperwork has been done.
- If you choose not to file a claim with your auto insurance company, or are uninsured, your account will be treated as a cash account, and all fees will be due at the time of service.

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY

Patient Signature: ______________________________ **Date:** ____________

AUTO ACCIDENT INFORMATION

Name: ______________________________ Date: ___/___/___ File #: __________

1) Billing information:

Your position in the car: ☐ Driver ☐ Front passenger ☐ Right rear passenger ☐ Left rear passenger

☐ Other: ______________________________

Vehicle you were in – Make: ______________ Model: ______________ Year: ______

Name of driver: ______________________________

Address: ______________________ City: ______________ State: ___ Zip: ______

Insurance company: ______________________ Phone #: ______________

Has a PIP claim been filed? ☐ Yes ☐ No If yes, claim #: ______________________

Other vehicle – Make: ______________ Model: ______________ Year: ______

Name of driver: ______________________________

Address: ______________________ City: ______________ State: ___ Zip: ______

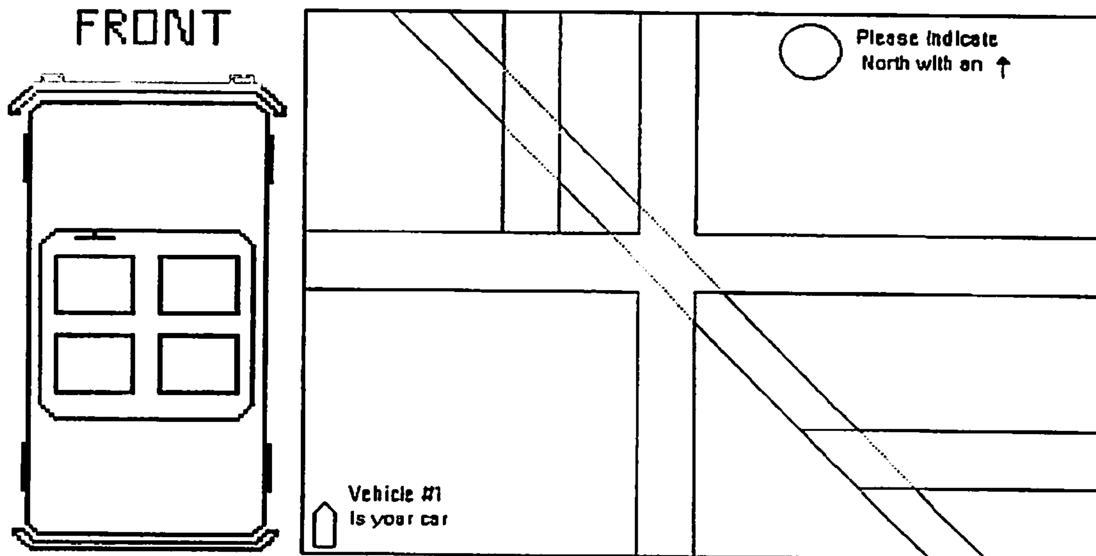
Insurance Co: ______________________ Claim #: ______________________

Have you consulted with an attorney? ☐ Yes ☐ No

Is an attorney representing you? ☐ Yes ☐ No

If yes, name: ______________________ Phone #: ______________

2) Mechanics of accident:



Shade areas of impact

Describe how accident occurred: ______________________________

____

____

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Were you wearing a seatbelt? ☐ Yes ☐ No
Were you wearing a shoulder harness? ☐Yes ☐ No
Did an airbag deploy at your position? ☐Yes ☐ No
Was a headrest available at your position? ☐Yes ☐ No

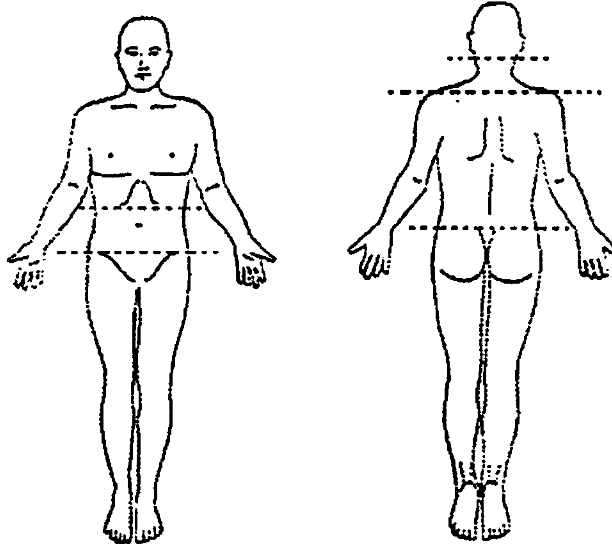
If yes, describe alignment: ____

At the time of impact, were you aware that an accident was about to occur? ☐Yes ☐ No
Did you brace for impact? ☐Yes ☐ No
At the time of the accident, were you: ☐ Looking forward; ☐ Looking to the right; ☐ Looking to the left
At the time of the accident, were you ☐ Stopped; ☐ Moving forward; ☐ Moving backwards; Approximate speed: _________ mph
Did you have a: ☐ Traffic light (color? ______); ☐ Stop sign; ☐ Yield sign; or ☐ No traffic control
This was a ☐ Head-on collision; ☐ Rear-end collision; ☐ "T-bone" collision; ☐ One care vs. stationary object; ☐ Car-bicycle accident; ☐ Car-pedestrian accident

4) Environmental conditions:

Date of accident: ___/___/___; Time of accident: ___:___ ☐ am ☐ pm
The weather was: ☐ Clear; ☐ Cloudy; ☐ Foggy
The road conditions were: ☐ Dry; ☐ Wet; ☐ Icy; ☐ Snow covered
The road surface was: ☐ Concrete; ☐ Asphalt; ☐ Dirt; ☐ Gravel
At the time of the accident, it was: ☐Raining; ☐ Drizzling; ☐ Snowing; ☐ Hailstorm; ☐ No precipitation - Dry

5) Symptoms and subjective complaints



Please note on the diagrams above any areas of contusions, bruising, cuts, lacerations, or scrapes.

Did you receive any injuries, bruises, or cuts as a result of the use of seatbelts, shoulder harness, headrest, or airbag deployment? ☐Yes ☐ No
If yes, please describe: ____

____

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Did you experience any of the following symptoms after the accident:

- ☐ Loss of consciousness
- ☐ Dizziness
- ☐ Confusion
- ☐ Tingling in arms or legs
- ☐ Numbness in arms or legs
- ☐ Neck pain
- ☐ Neck stiffness
- ☐ Low back pain
- ☐ Low back stiffness
- ☐ Blurred vision
- ☐ Disorientation
- ☐ Warm spots in your body
- ☐ Cold spots in your body
- ☐ Headaches

Have you had difficulty with any of the following daily activities since the accident?

- ☐ Sleeping
- ☐ Sitting
- ☐ Walking
- ☐ Eating
- ☐ Reading
- ☐ Concentrating
- ☐ Bowel movements

Please list any other daily activities that have been affected as a result of this accident:

____

____

____

How did you leave the scene of this accident: ☐ Drove same car; ☐ By ambulance;

☐ By fire department; ☐ By police; ☐ By a friend; ☐ Other: ______________

6) Accident investigation info:

Location of accident: ______________________________________

City: ______________ County: ______________ State: ________

Was this accident investigated by law enforcement? ☐ Yes ☐ No

If yes, which agency: ☐ City police; ☐ County police or sheriff; ☐ State police

Case #: ______________________________

Did you complete a State Accident form? ☐ Yes ☐ No

It is of the utmost importance that this form be thoroughly completed. Also, please bring in copies of ALL reports that were completed either by you or the police.

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Notice of Privacy Practices

Patient Name: ______________________________ **DOB:**______________________

This is an abbreviated Privacy Statement. Please see the front desk for a complete Privacy Statement.

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at this office. We need this record to provide you with the highest quality of care and to comply with local, state, and federal laws. This notice will tell you about the ways we may use and disclose your medical health care information. We also describe your rights and duties we have regarding the use and disclosure of your medical information.

Law requires us to:

- Keep your medical information private
- Make this notice available to you describing our legal duties, privacy practices, and your rights regarding your medical information.
- Follow the terms of the notice that is now in effect.

We have a right to:

- Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
- Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of changes to privacy practices:

- Before we make any important changes in our privacy practices, we will change this notice and make the revised notice available at our office upon request.

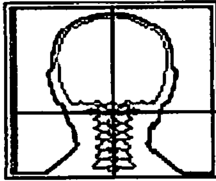
Use and disclosure of your medical information are as follows: treatment, payment, or healthcare operations; appointment reminders; disaster relief; fundraising; research; funeral director, coroner or medical examiner; specialized government functions; court order, judicial and administrative proceedings; public health activities; victims of abuse, neglect, or domestic violence; workers compensation; health oversight activities; and law enforcement. In all cases, we will release only the minimum amount of information necessary.

You have a right to look at or get copies of your medical information; receive a list of our business associates; receive a list or accounting of disclosures; request that we place additional restrictions on disclosure; request that we communicate with you by different means or to different locations; request that we change your medical information.

If you have any questions about this notice or if you think we may have violated your privacy rights, please contact our privacy officer. You may also submit a written complaint with the U.S. Department of Health and Human Services. The address is 200 Independence Avenue, S.W., Washington, D.C. 20201. You can call toll-free at 1-877-696-6775. We will not retaliate in any way if you choose to file a complaint.

______________________________ ______________________________

Patient Signature / Personal Representative Date



Atlas Spinal Care

Patient Confidential Communication

Patient Name:________________________________ DOB: _________________________

The Health Insurance Portability and Accountability Act (HIPAA) gives you the right to request that we communicate financial and/or medical information to you in confidence by a particular method. In order to protect the privacy and confidentiality of your information, please complete the following. This will tell us how you wish to be contacted and with whom we may discuss your health care.

You may contact me at the following phone numbers: (Provide all that apply)

Home Phone: ___________________ Cell Phone: ____________________ Work:___________________

____ Yes, you may leave a confidential message at: Home: ___ Cell: ___ Work:___ (Check all that apply)
____ Yes, you may leave the minimum necessary information on my answering machine or voice mail listed above.
____ Yes, you may provide the minimum necessary medical information to the individual(s) listed below:

Name:___________________________ Relationship: ___________________________
Name:___________________________ Relationship: ___________________________

Our office will continue to communicate with you according to your above response(s) until you change your preferences. You may do so by completing a new form. By signing below, you grant permission to the communication outlined above.

________________________________ ____________________________
Signature of Patient/ Personal Representative Date

Notice of Privacy Practices Acknowledgement

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Atlas Spinal Care.

Our Notice of Privacy Practices describes in more detail how your health history information may be used and disclosed, and how you can access your information.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

____
Patient or legally authorized individual signature Date Time

____
Printed name if signed on behalf of patient Relationship to patient (parent, legal guardian, etc)