

# 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\*

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? \_\_\_\_\_

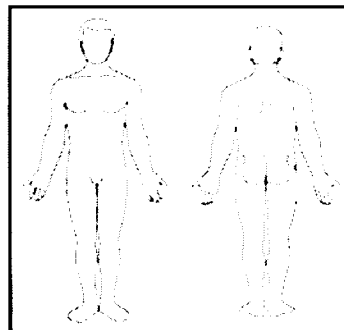
Does it interfere with your: Work  Sleep  Daily routine  Recreation

Activities/movements that are painful to perform: Sitting  Standing  Walking  Bending  Lying down

newpatientintake.docx

Driving  Reading

Please mark where it hurts



# \*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:

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

## STRESSORS :

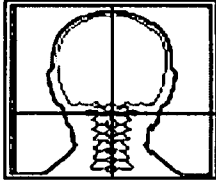
- SMOKING PACKS/DAY \_\_\_\_\_  
 ALCOHOL DRINKS/WEEK \_\_\_\_\_  
 COFFEE/CAFFEINE DRINKS CUPS/DAY \_\_\_\_\_  
 HIGH STRESS LEVEL REASON \_\_\_\_\_

## EXERCISE:

- NONE  
 MODERATE  
 HEAVY  
# DAYS PER WEEK \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_



# Atlas Spinal Care

## 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 Billing Information: \_\_\_\_\_ ; Treatment Information: \_\_\_\_\_ ; and Scheduling 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)

# 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.

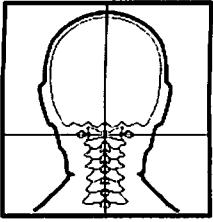
Use and disclosure of your medical information are as follows: treatment, payment, or healthcare operations; appointment reminders; disaster relief; fundraising; research; funeral director, coroner or medical examiner; specialized government functions; court order, judicial and administrative proceedings; 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. **Note: This authorization may be revoked at any time by giving a written notice to Atlas Spinal Care. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization.**

\_\_\_\_\_  
Patient Signature / Personal Representative

\_\_\_\_\_  
Date



# Atlas Spinal Care, P.C.

16500 SE 15<sup>th</sup> Street  
Suite 160  
Vancouver, WA 98683

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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.

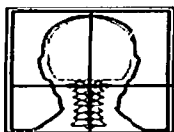
I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office of clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

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)



# Atlas Spinal Care

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## OFFICE POLICIES

Please be on time for your appointment. Being late or last minute cancellations can cause severe scheduling disruptions which can interfere with the quality of care you and other patients receive.

Please do not wear strong perfumes/colognes. We see many patients with allergies or respiratory problems. Strong scents can impair their progress.

Continued cancellations or missed appointments may result in being released from care. If you need to re-schedule an appointment, please call within 24 hours of your scheduled appointment.

Children are welcome in the clinic. You are responsible for your children's actions at all times. Our staff will assist you with your well-behaved children.

We may schedule you for multiple appointments. This will help insure convenient appointment times for you as well as provide you with the highest level of care possible.

If you need to spend extra time discussing your health concerns with your doctor, please let our staff know so we may schedule your next appointment accordingly.

Please notify your doctor of any changes in your health status regardless of the significance.

## FINANCIAL POLICIES

We accept the following forms of payment: Cash, Personal Checks, Debit Cards, Visa, Discover, American Express and Master Card.

Payment is expected at the time of your visit. We will bill your primary insurance company for Initial Intensive Care as a courtesy to you. The patient is always responsible for the payment of their care. An insurance contract is between the patient and their insurance company.

Insurance coverage is never guaranteed. If there are any problems between the insurance company and the patient, the latter may file a grievance directly with your insurance company. Your signature below assigns assignment to this office for collection of benefits and also authorizes this office to release daily chart notes when necessary for the processing of claims.

The office manager may approve account balances. Active monthly payments are required. Accounts with balances 30 days past due may be charged a service fee of 12% per year compounded monthly.

Any account where no payment has been received for sixty days may be sent to a third party collection agency. Any additional collection fees will be the responsibility of the patient. NSF checks or rejected credit card payments will be charged a service fee of \$35 per occurrence.

We do offer a *time of service discount* when services are paid in full at the time of the visit. This discounted amount will be passed on to your insurance company.

In some cases, we may have a contract with your insurance company governing how we handle your account. This contract may prevent us from offering you our *time of service discount*. Please ask us if you have any questions .

Feel free to ask us any financial questions you may have. Our intent is to provide you with the highest level of service as well as care

Your insurance company determines benefits when they receive our billings. Any statements made by our staff regarding your coverage in no way guarantees that your care here will be covered by your insurance company and you will be responsible for your account regardless of insurance

**By signing below, I acknowledge that I understand the policies as contained herein.**

Patient or guardian: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_