

Atlas Spinal Care, P.C.

16500 SE 15th Street
Suite 160
Vancouver, WA 98683

(360) 718 - 7944
Fax: (360) 718 - 7931

1

PATIENT INFORMATION

Name: _____
(First) (Initial) (Last) (Name called by)

Address: _____

Birthday: _____ Age: _____ Male Female

Social Security # _____/_____/_____

Occupation: _____

Employer: _____

Parents Name(if a minor): _____

Single Married Divorced Widowed Separated

Spouse/Partner's Name: _____

of Children: _____ Name(s) _____

2

INSURANCE

Who is responsible for this account? _____

Relationship to patient _____

Insurance company _____

Insurance ID number _____

Group / Claim number _____

Is patient covered by additional insurance? Yes No

Insurance company _____

Subscriber # and name _____

Birthdate _____ Group # _____

Please present insurance card(s) so we can put a copy in your file.

4

CONTACT INFORMATION

Home phone _____

Cell phone _____

Work Phone _____ Ext _____

Email _____

Best way to reach you Home Cell Work Email

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone _____ Cell _____

3

ACCIDENT INFORMATION

Is your condition due to an accident? No Yes Date: _____

Type of accident? Automobile Work Home Other

To whom have you reported the accident?

Insurance Worker's Comp Employer Other _____

Attorney Name (If applicable) _____

5

PATIENT CONDITION

What is your major symptom/problem? _____

When did your symptoms begin? _____

Have you had this problem before? _____

Is your condition getting progressively worse? Yes No

Is this problem: constant comes and goes

How does it Feel? Burning Sharp Shooting Dull Aching Stiff

Tingling Throbbing Swelling Other _____

Circle below the severity of your pain on a scale of 0 to 10:

(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe pain)

What makes your condition better? _____

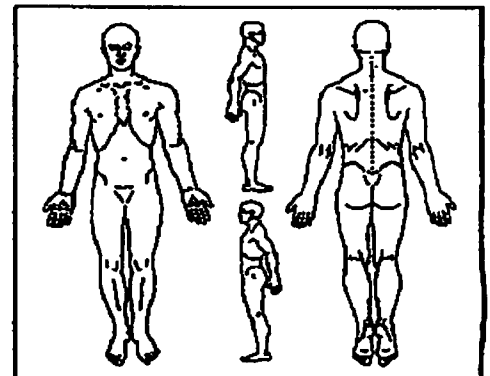
What makes your condition worse? _____

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

Please Mark Where it Hurts



6**HEALTH HISTORY**

What other treatments have you had for this condition?

-
- Chiropractic
-
- Orthopedic
-
- Neurologist
-
- Physical Therapy
-
- Medication
-
- Surgery

Name of other doctors who have treated you for this condition _____

Describe the other doctor's treatment for your condition _____

Previous Chiropractic care? No Yes Date _____ Local Out of state _____

Date of Last: Physical Exam _____ Spinal x-ray _____ MRI _____

Spinal Exam _____ Dental x-ray _____ CT- Scan _____

List any Medications you are taking _____

Vitamins / Herbs / Minerals _____

Females: Are you Pregnant Yes No Beginning of last menstrual cycle _____

Check any of the following conditions you have had:

- | | | |
|---|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Ear ringing | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Headaches | <input type="checkbox"/> Poor circulation |
| <input type="checkbox"/> Arm/shoulder pain | <input type="checkbox"/> Headaches - Migraine | <input type="checkbox"/> Prostate problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Bladder problems | <input type="checkbox"/> Herniated disk | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sinus infection |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Deafness | <input type="checkbox"/> Irregular cycle | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Digestion problems | <input type="checkbox"/> Leg pain | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Earache | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Vertigo/Dizziness |

STRESSORS

- | | |
|--|-------------------|
| <input type="checkbox"/> Smoking | Packs/Day _____ |
| <input type="checkbox"/> Alcohol | Drinks/Week _____ |
| <input type="checkbox"/> Coffee/ Caffeine Drinks | Cups/Day _____ |
| <input type="checkbox"/> High Stress Level | Reason _____ |

EXERCISE

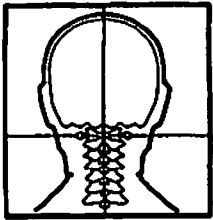
-
- None
-
-
- Moderate
-
-
- Daily
-
-
- Heavy

Have you had any:	Description	Date
Automobile accidents	_____	_____
Surgeries	_____	_____
Broken bones	_____	_____
Falls/Head injuries	_____	_____

7**AUTHORIZATION**

Insurance verification and authorization is not a guarantee of payment. I understand that I may be responsible for any balance that is not paid by insurance. I authorize Atlas Spinal Care and Dr. Jonathon or Dr. Tara Douglas to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided. I authorize the use of this signature on all insurance submissions.

Signature_____
Date_____
Parent (if patient is a minor)



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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

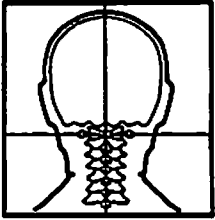
- All worker's compensation cases will be billed directly to the insurance company, provided the appropriate paperwork has been filled out and a claim has been filed. If the claim is denied, we will bill your private insurance carrier if you have coverage. Please keep in mind that if your claim is denied,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



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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)