ATLAS SPINAL CARE
16500 SE 15th St Suite 160 Vancouver, WA 98683
Phone (360) 718- 7944
Fax (360) 718- 7931

PATIENT INFORMATION

Patient Name:_____ If a Minor, Responsible Party:_____
Gender Identity:_____ Legal Sex:_____ Preferred Pronouns:_____
Address:_____ City:_____ State:_____ Zip:_____
Birth Date:_____/_____/_____ Age:_____ Social Security #: _____-_____-_____
Occupation:_____ Employer:_____
Marital Status:_____ No. of children:_____ Email:_____
Home #:_____ Work #: _____Cell: _____ Best way to contact:_____
Emergency Contact: Name: _____ Relationship:_____
Home #: _____ Cell #:_____
Who may we thank for referring you?_____

INSURANCE

Primary Policy Holder:_____ Relationship to Patient:_____
Primary Insurance Company: _____ ID#:_____ Group#:_____
Primary Policy Holder:_____ Birth Date:_____/_____/_____

HEALTH HISTORY

What other treatments have you had for your current complaints?
☐Chiropractic ☐Physical Therapy ☐Neurologist ☐Medication ☐Surgery ☐Orthopedic
☐Massage Therapy ☐Other:_____
List any allergies you currently have (food, medication, etc): _____
_____
List any medications/vitamins you are currently taking:_____
_____
Previous surgeries and dates:_____
Broken bones and dates:_____
Falls/injuries and dates:_____

Stressors:

☐Smoking Packs/Day_____
☐Alcohol Drink/Week_____
☐Caffeine Cups/Day_____
☐High Stress Level Reason_____

Exercise:

☐None
☐Moderate
☐Heavy
_____# of days/week

Please list who your other healthcare providers are:
Primary Care Physician: _____Surgeon: _____
Neurologist: _____ Physical Therapist: _____
Other Medical Provider(s): _____

PATIENT CONDITION

Main area of complaint:_____
When did your symptoms begin?_____
Have you had this problem in the past? ☐Yes ☐No
Is your condition getting progressively worse?
☐Yes ☐No
This problem is: ☐Constant ☐Comes and 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 makes your condition worse?_____
_____
Does it interfere with: ☐Work ☐Sleep ☐Daily
☐Routine ☐Recreation
Other areas of complaint:_____
_____
_____

Main area of complaint:_____
When did your symptoms begin?_____
Have you had this problem in the past? ☐Yes ☐No
Is your condition getting progressively worse?
☐Yes ☐No
This problem is: ☐Constant ☐Comes and 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 makes your condition worse?_____
_____
Does it interfere with: ☐Work ☐Sleep ☐Daily
☐Routine ☐Recreation
Other areas of complaint:_____
_____
_____

Circle any of the following conditions you have had or are currently experiencing:

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
Type 1 Type 2	Hepatitis	Herniated Disk	Insomnia	Kidney Problems
Heart Disease	Neck Pain	Mid-Back Pain	Migraines	
Leg Pain	Osteoporosis	Poor Circulation	Prostate Issues	
Low Back Pain	Scoliosis	Shingles	Rheumatoid Arthritis	

The statements on this form are accurate to the best of my knowledge and I agree to be examined at Atlas Spinal Care for treatment of my symptoms.

Patient Signature: _____ Date:_____

FOR MASSAGE PATIENTS ONLY

What type of pressure do you prefer? Light Moderate Deep Not Sure

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INFORMED CONSENT FOR CHIROPRACTIC CARE AND MASSAGE THERAPY

Washington State Law requires that chiropractic patients be provided with the following information prior to being treated.

Chiropractic examination and therapeutic procedures (including spinal adjustments, muscle therapy, exercise and traction) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications include but are not limited to soreness, inflammation, soft tissue injury, dizziness and temporary worsening of symptoms. More serious complications are extremely rare.

Alternatives to chiropractic care include but are not limited to medical treatment, physical therapy, acupuncture and massage. If you have any questions, please feel free to discuss them with the doctor.

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation; relief of muscular tension, spasm or pain; or for increasing circulation or energy flow. If I experience any pain or discomfort during the session, I will IMMEDIATELY INFORM the practitioner so the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see my primary health care provider or other qualified medical specialists for such services. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe pharmaceuticals, or treat any physical or mental illness. I affirm that I have stated all my known medical conditions and answered all my questions honestly and completely. I understand any sexual misconduct will not be tolerated and the massage will be terminated immediately. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioners part should I forget to do so.

I have read, or have had read to me, the above consent. By signing below I agree to to the above and allow the doctor or associates, affiliated with *Atlas Spinal Care* to perform such. I intend this consent for to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I also understand that there is no guarantee or warranty for a specific cure or result.

Patient Name (Printed):_____

Patient Signature:_____ Date:_____
(or patient representative) *(indicate relationship if signing for patient)*

Pregnancy Release:
This is to certify that to the best of my knowledge I am not pregnant and the doctor and/or associates have my permission to preform an x-ray evaluation. I have been advised that an x-ray can be hazardous to an unborn child.

Patient Signature:_____ Date:_____

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FINANCIAL & 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.

We understand that unanticipated events happen occasionally. In our desire to be effective and fair to all of our clients and out of consideration for our therapists time, there will be a **$40 CANCELLATION FEE** if you are unable to provide a 12 hour advance notice and we are unable to fill your spot; or no-show more than one time. This cancellation fee must be paid in full prior to your next scheduled treatment. Continued cancellations or missed appointments may result in being released from care. If you need to re-schedule an appointment, please call within 12 hours of your scheduled appointment.

INSURANCE WILL NOT COVER CANCELLATION OR NO SHOW FEES, INCLUDING AUTO ACCIDENT INSURANCE.

Anyone who is not present for the scheduled session during the first 20 minutes will be considered "no show". Anyone who is late and has notified us will have the option to receive a massage for the remaining time of the appointment. Regardless of the length of the treatment, charges will be for the full session.

We accept the following forms of payment: Cash, Personal Checks, Debit Cards, Visa, Discover, American Express and Master Card. There will be a 3% service fee for all payments made on a credit or debit card over $1,000.

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.

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 Signature:_____ Date:_____

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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 healthcare.

You may contact me at the following phone numbers:
Home Phone:_____ Cell Phone:_____Work Phone:_____
☐Yes, you may leave a confidential message at: Home Cell Work
☐Yes, you may leave the minimum necessary information on my answering machine or voice mail.
☐Yes, you may provide Billing Information Treatment Information 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.

Patient Signature:_____ Date:_____
(or patient representative) *(indicate relationship if signing for patient)*

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy the 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 on the following page.

Patient Signature:_____ Date:_____
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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 to 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 uses and disclosure of your medical information.

Law requires us to:

- Keep your medical information private.
- Make this notice available to you describing your 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 the right to look at or get copies of your medical information; receive a list of our business associates; receive a list of 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.**