INITIAL COMPLAINT

Northwest Chiropractic Center, PLLC 13030 121st Way NE #102, Kirkland, WA 98034 Office (425) 814-2800

Patient Name:______________________________ **Date:**______________

Primary Care Physician & Clinic: ______________________________ **Phone: (** ______________

Doctors treating you for this condition: ______________________________ **Phone: (** ______________

Therapists treating you for this condition: ______________________________ **Phone: (** ______________

Date of initial onset for this condition:______________ **If reoccurrence, date of current aggravation:**______________

Describe how the injury occurred:____

____

When did your problem begin? ☐ **Immediately after a specific incident** ☐ **Multiple incidents** ☐ **Gradually developed**

☐ **No specific incident - Please list the "incident/s":** ______________________________

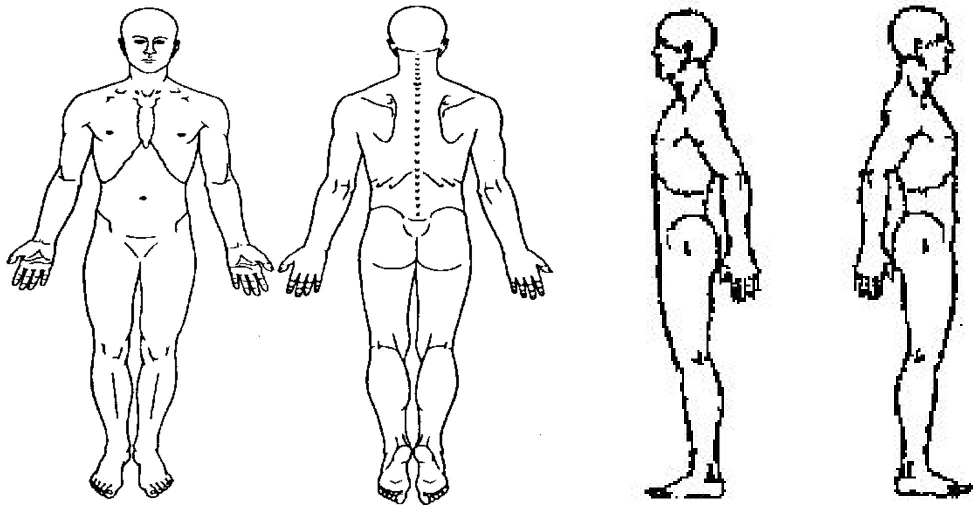
Pain Diagram: Use symbols below to mark the figures.

Description:

- XXX = Aching
- / / / = Numbness
- >>> = Stabbing
- ### = Burning
- 000 = Pins/Needles
- TTT = Throbbing

Frequency (overall):

- ☐ Constant (76-100%)
- ☐ Frequent (51-75%)
- ☐ Intermittent (26-50%)
- ☐ Occasional (25% or less)



Rate Intensity as Follows (This Section):

0 None	4 Moderate, bothers during work/activities	8 Intense, preoccupied, seeks relief instead of activity
1 Maybe	6 Limiting, prevents full activity	10 Severe—on bed rest, stops all activity
2 Mild, forgotten w/activity		

"**O**" "**X**" Place a box on "☐"

Complaint (I.e. Neck Pain, Low Back Pain) **Circle** your worst pain, "**X**" for average pain, "[ ]" pain now		Is it getting **Better**	**Worse**	**No Change**
1.______________________	0….1…..2…..3…..4…..5…..6…..7…..8…..9…..10	☐	☐	☐
2.______________________	0….1…..2…..3…..4…..5…..6…..7…..8…..9…..10	☐	☐	☐
3.______________________	0….1…..2…..3…..4…..5…..6…..7…..8…..9…..10	☐	☐	☐
4.______________________	0….1…..2…..3…..4…..5…..6…..7…..8…..9…..10	☐	☐	☐

What daily functions are you having any issues with: **(Please circle all that you are feeling limitation/pain with)**

Sleeping, Personal Care (Washing, Dressing), Travel, Work, Recreation, Lifting, Walking, Standing, Exercise

Your general stress level: ☐ **No stress** ☐ **Minimal stress** ☐ **Moderate stress** ☐ **Greatly stressed**

Physical activity at work: ☐ **Sitting more than 50% of day** ☐ **Light manual labor** ☐ **Manual labor** ☐ **Heavy manual labor**

General physical activity: ☐ **No regular exercise program** ☐ **Light exercise program** ☐ **Strenuous exercise program**

Please describe any other medical concerns that you are considering seeking care for, or are currently receiving care for, or in the past have sought care for: ______________________________

____

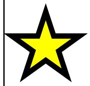
____

Northwest Chiropractic Center, PLLC
(425) 814-2800

MEDICAL HISTORY

13030 121st Way NE Suite 102, Kirkland, WA 98034

Print Patient Name:______________________________ **Date:** ______________



Patient Initials:

_______ **For Re-Exams / Updates ONLY – Please initial IF there has been NO changes since you last filled out this form.**

For ALL Patients who are new or have had a new injury/area of complaint please answer the following.

If you have ever been treated for a listed condition in the past, please check it in the Past column.
If you are currently under the care of a medical professional for a listed condition, check it in the Present column.

Past	Present	Condition
☐	☐	Neck Pain (723.1)
☐	☐	Shoulder Pain (719.41)
☐	☐	Pain in Upper Arm or Elbow (719.42)
☐	☐	Hand Pain (719.44)
☐	☐	Wrist Pain (719.43)
☐	☐	Upper Back Pain (724.1)
☐	☐	Low Back Pain (724.2)
☐	☐	Pain in Upper Leg or Hip (719.45)
☐	☐	Pain in Lower Leg or Knee (729.5)
☐	☐	Pain in Ankle or Foot (719.47)
☐	☐	Jaw Pain (526.9)
☐	☐	Swelling/Stiffness of Joint(s)
☐	☐	Fainting (780.2)
☐	☐	Visual Disturbances (368.9)
☐	☐	Convulsions (780.3)
☐	☐	Dizziness (780.4)
☐	☐	Headache (784.0)
☐	☐	Muscular Incoordination (781.3)
☐	☐	Tinnitus (Ear Noises) (388.30)
☐	☐	Rapid Heart Beat (785.0)
☐	☐	Chest Pains (786.50)
☐	☐	Loss of Appetite (783.0)
☐	☐	Anorexia (307.1)
☐	☐	Abnormal Weight ☐ Gain (783.1) ☐ Loss (783.2)
☐	☐	Excessive Thirst (783.5)
☐	☐	Chronic Cough (786.2)
☐	☐	Chronic Sinusitis (473.9)
☐	☐	General Fatigue (780.7)
☐	☐	Irregular Menstrual Flow (626.4)
☐	☐	Profuse Menstrual Flow (626.7)
☐	☐	Breast Soreness/Lumps (611.72)
☐	☐	Endometriosis (617.9)
☐	☐	PMS (625.4)
☐	☐	Loss of Bladder Control (788.30)
☐	☐	Painful Urination (788.1)
☐	☐	Frequent Urination (788.41)
☐	☐	Abdominal Pain (789.0)
☐	☐	Constipation/Irregular Bowel Habits (564.0)
☐	☐	Difficulty in Swallowing (787.2)
☐	☐	Heartburn/Indigestion (787.1)
☐	☐	Dermatitis/Eczema/Rash (692.9)
☐	☐	Depression (311)

Past	Present	Condition
☐	☐	Aortic Aneurysm (441.5)
☐	☐	High Blood Pressure (401.9)
☐	☐	Angina (413.9)
☐	☐	Heart Attack (410.9)
☐	☐	Stroke (436)
☐	☐	Asthma (493.9)
☐	☐	Cancer (199.1)
☐	☐	Tumor (229.9)
☐	☐	Prostate Problems (601.9)
☐	☐	Blood Disorder (790.6)
☐	☐	Emphysema (chronic lung disorders) (492.8)
☐	☐	Arthritis (716.9)
☐	☐	Rheumatoid Arthritis (714.0)
☐	☐	Diabetes (250.0)
☐	☐	Epilepsy (349.5)
☐	☐	Ulcer (556.9)
☐	☐	Liver (573.9) / Gallbladder (575.9) problems
☐	☐	Kidney Stones (592.0)
☐	☐	Hepatitis (573.3)
☐	☐	Bladder Infection (595.9)
☐	☐	Kidney Disorders (by condition)
☐	☐	Colitis (558.9)
☐	☐	Irritable Colon (564.1)
☐	☐	HIV/AIDS (042)
☐	☐	Systemic Lupus
☐	☐	Other ______________________

If you or a family member has had any of the following, please mark the appropriate box:

☐ Cancer	☐ Epilepsy
☐ Rheumatoid Arthritis	☐ Chronic Back Problems
☐ Diabetes	☐ Chronic Headaches
☐ Heart Problems	☐ Lupus
☐ Lung Problems	☐ Other Conditions __________
☐ High Blood Pressure	________________

Yes	No	
☐	☐	Do you have a permanent disability rating?
☐	☐	Location ______________________
☐	☐	Date rating received ____/____/____
		Rating Percentage ______%

Please check any of the following that apply to you.

Past	Present	
☐	☐	Pregnancy (V22.2)
☐	☐	Birth Control Pills
☐	☐	Hormonal/Estrogen Replacement
☐ ☆	☐	Medications (please list) ______________________
☐	☐	Vitamins/Herbs______________
☐	☐	Hospitalization/Surgical Procedures (please list) ______________________

Past	Present	
☐	☐	Tobacco (305.1)
☐	☐	Alcohol (305.0)
☐	☐	Drug or Alcohol Dependence (303.9)
☐	☐	Coffee/Tea/Caffeinated Soft Drinks: Cups/Cans per day ________________

BLOOD PRESSURE: ____________

Present Weight: _______ pounds **Height:** ____ feet ____ inches

PLEASE NOTE ANY ADDITIONAL COMMENTS/GENERAL HEALTH CONCERNS: ______________________

____

____

NORTHWEST CHIROPRACTIC CENTER, PLLC
INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND MASSAGE CARE

Chiropractic treatment consists of manipulations of joints and soft tissues, using the hand and/or a mechanical instrument. You may feel joint movement, and you may hear joint clicks or other noises. Some patients will feel some stiffness and soreness following the first few days of treatment. These are normal and not a cause for concern. There are different techniques used in Chiropractic spinal manipulations. There are also alternatives to Chiropractic care, including but not limited to: Physical Therapy, Massage therapy, Osteopathic manipulations, and Medical care. There are also material risks inherent in the above listed alternatives, which should be discussed between you and the specialty care provider. You also have the option of not seeking any care. The risk of remaining untreated allows the formation of adhesions and reduces mobility, which sets up a pain reaction further reducing mobility.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are certain risks which may arise during the exam and treatment. Those complications include: strokes or stroke-like conditions, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy, pathological fracture, cervical disc protrusions, cervical dislocations, costovertebral strains, rib fractures, costochondral separations, compression of the cauda equina. 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, are in my best interest. The risks of massage are bruising, local tenderness, and the release of toxins in the body. There are also risks in taking nutritional supplements, please contact your Primary Care Physician/health care practitioner before using any nutritional products, including those dispensed in this office.

I have read or have had read to me the above explanation of the nature and purpose of chiropractic adjustments, other alternatives/procedures for care, massage, and possible risks. I have also had the opportunity to ask questions about its content and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended, and listed below. Having been informed of the risks, **I hereby request and consent to the performance of** chiropractic adjustments, other chiropractic procedures, and diagnostic x-rays-if warranted, massage, and the use of natural substances such as vitamins, minerals, or other natural substances on me or on the patient named below, for whom I am legally responsible, by the doctor of chiropractic named below and/or licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or servicing as backup for the doctor of chiropractic named below and by the Licensed Massage Therapist listed below, including those working at the clinic or office listed below or any other office or clinic. 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.

The anticipated results of the proposed treatment as described by Dr./LMT ________________________________is:

(to be completed by the Doctor / LMT) ____

____

____.

****

***To be completed by patient*:**

____

PRINT Patient's Name

____

Signature of Patient

____

Date

If patient is a ***MINOR,*** *this section to be complete by patient's legal guardian, legally responsible adult.*

____

PRINT Patient's Name

____

PRINT Name of Patient's Guardian

____

Signature of Patient's Guardian

____

Date

To be completed by Doctor/LMP

Northwest Chiropractic Center, PLLC
13030 121st Way NE Suite 102
Kirkland, WA 98034
(425) 814-2800
Fax (425) 823-0882

Name of Doctor(s)/LMP treating this patient:

Lew Estabrook, D.C., Member
Tim Clanton, DC
Caedin Pettigrew, D.C.
Jason Gilmore, DC
Jennifer Wassler, LMP
____________________,
____________________,

____

Provider's Signature

____

Date

____

Translated by:

____

Date

FINANCIAL POLICY & AUTHORIZATION WAIVER 2017 06/15/17

Northwest Chiropractic Center, PLLC 13030 121st Way NE Suite 102, Kirkland, WA 98034 (425) 814-2800

Our FINANCIAL POLICY is as follows:

1. As a patient in this office you are directly responsible for payment of all charges incurred while under treatment; it is **your responsibility** as the subscriber to know your benefits and limitations/exclusions.
2. If you have a co-pay amount, then your co-pay is due at time of each service, along with co-insurance.
3. If your deductible has not been met then we will collect the **Allowed Amount** at time of service.
4. If your insurance company requires a referral/prescription for benefits it is **your responsibility** to contact your doctor to receive the needed referral. Our office will not call your provider for a referral.
5. If your insurance company requires authorization, we will attempt to promptly receive authorization**.** You will be responsible for all full payment for non-covered services and if your insurance company denies care for any reason: maintenance, preventive, wellness, maxed medical necessity, authorization not pre-authorized or denied.
6. All supports, supplements and supplies must be paid for at time of service. Insurance does not cover supplies.
7. Missed Massage Appointments are charged $80. Canceling with less than 24 hours notice, one full business day, is also considered a missed massage and subject to an $80 charge. Late arrivals & leaving early; the patient is responsible for their missed portion $. We do not bill insurance companies for missed appointments.
8. Overdue accounts over ninety (90) days will be acted upon for collection, 1.0 % per month is charged on accounts. There is a $20.00 charge on all returned checks, and payment is due in the amount of the check plus the check fee within ten (10) working days [RCW 62A.3-515]. Once your account is sent to collections you will be discharged from all future care in our office.
9. If you're a new patient, or have an appointment that requires an **exam**, additional costs may incur and may not be covered by your insurance. **Please call your insurance to know what your benefits are for exams and re-exams (billing codes 99201-99213).** Some chiropractic work also falls under "rehab" on different policies and is processed differently. Again please call your insurance company for clarification (billing codes 98940, 97140, 97110, 98943)
10. **CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR PURPOSE OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS & FINANCIAL AGREEMENT: HIPAA** I hereby authorize *Northwest Chiropractic Center, PLLC* to use and disclose the health & medical information, via fax, mail or electronically for the purpose of treatment, payment and Health Care Operations. I also authorize the physician to release any information to referring/consulting physicians or other health care providers, as your physician deems appropriate to facilitate my/our care. I hereby assign payment to be directly issued to *Northwest Chiropractic Center, PLLC* for any benefits available under my coverage and/or settlement for treatment and/or expenses incurred at this office. I agree that this Assignment of Benefits and Authorization to release information is irrevocable and that I am waiving the statute of limitations for payment.
11. **AUTHORIZATION WAIVER:**
Authorization is required for most insurance companies in order to receive covered chiropractic and/or massage care. Please contact your insurance company to see if you need a referral and/or authorization.

I want to be seen for all appointments I schedule, but if I do not have authorization I agree to be financially responsible for the care given to me. I understand that my insurance requires pre-authorization for services and that Northwest Chiropractic Center, PLLC will attempt to get authorization. Authorization is not guaranteed and may be denied for any reason: maintenance, preventive, wellness, maxed medical necessity, authorization was not attained in a timely manner, not pre-authorized or denied.

If I choose to schedule any appointments without authorization, I understand that I will be financially responsible.

By signing below I agree to the Financial Policy and Authorization Waiver listed above.

PRINTED Patient Name	**Patient / Guardian Signature**	**Date**

You must be over 18 to sign this form

Northwest Chiropractic Center, PLLC

Lew Estabrook, DC, Member

13030 121st Way NE Suite 102
Kirkland, WA 98034
Phone: 425-814-2800 ~ Fax: 425-823-0882

Consent to use and Disclose PHI& Acknowledgement of Privacy Policy & Text/Emails

Use and Disclosure of your Protected Health Information
Your Protected Health Information will be used by **Northwest Chiropractic Center, PLLC** or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas
Describe and Notify private areas available upon request

Revocation of Consent
You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Initial → __________ Patient Initials **I have received a copy of the Notice of Patient Privacy Policy**.

☐ **By checking this box I consent to receive text/email appointment reminders ~ email for billing issue.** I understand that email and text messaging are not confidential methods of communication and may be insecure. I further understand that there is a risk that the email/text messaging might be intercepted and read by a third party.

By my signature below I give my permission to use and disclose my protected health information & I also acknowledge receipt of the Notice of Privacy Policy and consent to use text/emails if checked above.

Sign →
Patient (Over the age of 18) or Legally Authorized Individual Signature ____________ Date

Print →
Print Patient's Full Name ____________ Time

Witness Signature ____________ Date