PINEHURST CHIROPRACTIC
DAVID KIRDAHY, D.C.
2611 NE 125TH ST. SUITE 115
SEATTLE, WA 98125
(206) 365-2233 FAX: (206) 361-7082

INTAKE PAPERWORK FOR MINORS

Name:_____ **Date:**_____

Address:_____

How would you prefer to be reminded of future appointments:_____

Text_____ phone carrier:_____ or Email:_____

Phone number:_____ **Birthday:**_____

Parent/ guardian: _____ **phone#:**_____

Have you ever received Chiropractic Care? Yes___ No___ If yes, when?_____

Name of most recent Chiropractor:

_____

Reasons for seeking chiropractic care:

_____

On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
When did the symptom begin? _____ **suddenly or gradually?**_____
How did the symptom begin? _____
What makes the symptom worse? (circle all that apply):Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____

What makes the symptom better? (Circle all that apply): Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, other (please describe): _____

Describe the quality of the symptom (circle all that apply): Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, other (please describe): _____

Does the symptom radiate to another part of your body (circle one): yes no
If yes please indicate where:_____
Is the symptom worse at certain times of the day or night? (Circle one)
Morning Afternoon Evening Night Unaffected by time of day
Previous illnesses you've had in your life: _____
Previous Injury or Trauma:_____
Have you ever broken any bones? Which?_____
Allergies:_____
Medications:_____

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WE ARE COMMITTED TO PRESERVING THE PRIVACY OF YOUR PERSONAL HEALTH INFORMATION. IN FACT, WE ARE REQUIRED BY LAW TO PROTECT THE PRIVACY OF YOUR MEDICAL INFORMATION AND TO PROVIDE YOU WITH NOTICE DESCRIBING HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

WE ARE REQUIRED BY LAW TO HAVE YOUR WRITTEN CONSENT BEFORE WE USE OR DISCLOSE TO OTHERS YOUR MEDICAL INFORMATION FOR PURPOSES OF PROVIDING OR ARRANGING FOR YOUR HEALTH CARE, THE PAYMENT FOR REIMBURSEMENT OF THE CARE WE PROVIDE YOU, AND THE RELATED ADMINISTRATIVE ACTIVITIES SUPPORTING YOUR TREATMENT.

AS OUR PATIENT, YOU HAVE IMPORTANT RIGHTS RELATED TO INSPECTING AND COPYING YOUR MEDICAL INFORMATION THAT WE MAINTAIN, AMENDING OR CORRECTING THAT INFORMATION, OBTAINING AN ACCOUNTING OF OUR DISCLOSURES OF YOUR MEDICAL INFORMATION, REQUESTING THAT WE COMMUNICATE WITH YOU CONFIDENTIALLY, REQUESTING THAT WE RESTRICT CERTAIN USES AND DISCLOSURES OF YOUR HEALTH INFORMATION, AND COMPLAINING IF YOU THINK YOUR RIGHTS HAVE BEEN VIOLATED.

WE HAVE AVAILABLE A NOTICE OF PRIVACY PRACTICES WHICH FULLY EXPLAINS YOUR RIGHTS AND OUR OBLIGATIONS UNDER THE LAW. WE MAY REVISE OUR NOTICE FROM TIME TO TIME. IN THE EVENT THAT WE DO REVISE OUR NOTICE YOU WILL BE NOTIFIED AND ASKED TO SIGN A NOTIFICATION OF ACKNOWLEDGEMENT OF THE REVISED NOTICE.

YOU HAVE THE RIGHT TO RECEIVE A COPY OF OUR MOST CURRENT NOTICE IN EFFECT. IF YOU HAVE NOT YET RESERVED A COPY OF OUR CURRENT NOTICE, AND WOULD LIKE ONE, PLEASE ASK AT THE FRONT DESK AND WE WILL PROVIDE YOU WITH A COPY.

IF YOU HAVE ANY QUESTIONS REGARDING THIS MATTER OR ABOUT ANY OF YOUR MEDICAL INFORMATION, PLEASE CONTACT AMY SELENA AT (206) 365-2233.

SIGNED_____ DATE_____

WITNESS_____ DATE_____

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INFORMED CONSENT

CHIROPRACTIC

IT IS IMPORTANT TO KNOW THE DIFFERENCE BETWEEN THE HEALTH CARE SPECIALTIES OF CHIROPRACTIC, OSTEOPATHY, AND MEDICINE. CHIROPRACTIC HEALTH CARE SEEKS TO RESTORE HEALTH THROUGH NATURAL MEANS WITHOUT THE USE OF MEDICINE OR SURGERY. THIS GIVES THE BODY MAXIMUM OPPORTUNITY TO UTILIZE ITS INHERENT RECUPERATIVE POWERS. THE SUCCESS OF THE CHIROPRACTIC DOCTOR'S PROCEDURES OFTEN DEPENDS ON ENVIRONMENT, UNDERLYING CAUSES, PHYSICAL, AND SPINAL CONDITIONS. IT IS IMPORTANT TO UNDERSTAND WHAT TO EXPECT FROM CHIROPRACTIC HEALTH CARE SERVICES.

ANALYSIS

A DOCTOR OF CHIROPRACTIC CONDUCTS A CLINICAL ANALYSIS FOR THE EXPRESS PURPOSE OF DETERMINING WHETHER THERE IS EVIDENCE OF VERTEBRAL SUBLUXATION SYNDROME (VSS) OR VERTEBRAL SUBLUXATION COMPLEXES (VSC). WHEN SUCH VSS AND VSC COMPLEXES ARE FOUND, CHIROPRACTIC ADJUSTMENTS AND ANCILLARY PROCEDURES MAY BE GIVEN IN AN ATTEMPT TO RESTORE SPINAL INTEGRITY. IT IS THE CHIROPRACTIC PREMISE THAT OPTIMAL SPINAL ALIGNMENT ALLOWS OPTIMAL NERVE TRANSMISSION THROUGHOUT THE BODY. THIS GIVES THE BODY THE OPPORTUNITY TO USE ITS INHERENT RECUPERATIVE POWERS TO SELF REGULATE AND NORMALIZE THE BODY'S FUNCTIONS. DUE TO THE COMPLEXITIES OF NATURE, IT IS IMPOSSIBLE FOR ANY DOCTOR TO GUARANTEE SPECIFIC RESULTS. RESULTS DEPEND UPON THE INHERENT RECUPERATIVE POWERS OF THE BODY.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A PATIENT, IN COMING TO THE DOCTOR OF CHIROPRACTIC, GIVES THE DOCTOR PERMISSION AND AUTHORITY TO CARE FOR THE PATIENT IN ACCORDANCE WITH THE CHIROPRACTIC TESTS, ANALYSIS, AND DIAGNOSIS. THE CHIROPRACTIC ADJUSTMENTS OR OTHER CLINICAL PROCEDURES ARE USUALLY BENEFICIAL AND SELDOM CAUSE ANY PROBLEMS. IN RARE CASES UNDERLYING PHYSICAL DEFECTS, DEFORMITIES, OR PATHOLOGIES MAY RENDER THE PATIENT SUSCEPTIBLE TO INJURY. THE DOCTOR, OF COURSE, WILL NOT GIVE A CHIROPRACTIC ADJUSTMENT, OR HEALTH CARE, IF HE/SHE IS AWARE SUCH CARE MAY BE CONTRAINDICATED. AGAIN, IT IS THE RESPONSIBILITY OF THE PATIENT TO MAKE IT KNOWN OR TO LEARN THROUGH HEALTH CARE PROCEDURES WHATEVER HE/SHE IS SUFFERING FROM: LATENT PATHOLOGICAL DEFECTS, ILLNESSES, OR DEFORMITIES WHICH WOULD OTHERWISE NOT COME TO THE ATTENTION OF THE DOCTOR OF CHIROPRACTIC. THE PATIENT SHOULD LOOK TO THE CORRECT SPECIALIST FOR PROPER DIAGNOSTIC AND CLINICAL PROCEDURES. THE DOCTOR OF CHIROPRACTIC PROVIDES A SPECIALIZED, NON-DUPLICATING HEALTH SERVICE. THE DOCTOR OF CHIROPRACTIC IS LICENSED IN A SPECIAL PRACTICE AND IS ABLE TO WORK WITH OTHER TYPES OF PROVIDERS IN YOUR HEALTH CARE REGIME.

RESULTS

THE PURPOSE OF CHIROPRACTIC SERVICES IS TO PROMOTE NATURAL HEALTH THROUGH THE REDUCTION OF THE VSS OR VSC. SINCE THERE ARE SO MANY VARIABLES, IT IS DIFFICULT TO PREDICT THE TIME SCHEDULE OR EFFICACY OF THE CHIROPRACTIC PROCEDURES. IN SOME INSTANCES THE RESPONSE IS PHENOMENAL. IN MOST CASES, HOWEVER, THERE IS A MORE GRADUAL YET QUITE SATISFACTORY RESPONSE. OCCASIONALLY, THE RESULTS ARE LESS THAN EXPECTED. TWO OR MORE SIMILAR CONDITIONS MAY RESPOND DIFFERENTLY TO THE SAME CHIROPRACTIC CARE. MANY MEDICAL FAILURES FIND QUICK RELIEF THROUGH CHIROPRACTIC. IN RETURN, WE MUST ADMIT THAT CONDITIONS WHICH DO NOT RESPOND TO CHIROPRACTIC CARE MAY COME UNDER CONTROL OR BE HELPED BY MEDICAL SCIENCE. THE FACT IS THAT THE SCIENCE OF CHIROPRACTIC AND MEDICINE MAY NEVER BE SO EXACT AS TO PROVIDE DEFINITE ANSWERS TO ALL PROBLEMS. BOTH HAVE MADE GREAT STRIDES IN ALLEVIATING PAIN AND CONTROLLING DISEASE.

TO THE PATIENT

PLEASE DISCUSS ANY QUESTIONS OR PROBLEMS WITH THE DOCTOR BEFORE SIGNING THIS STATEMENT OF POLICY.

I HAVE READ AND UNDERSTAND THE FOREGOING.

SIGN_____DATE_____

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FINANCIAL POLICY

IT IS THE POLICY OF THIS CLINIC THAT ALL FEES FOR SERVICES RENDERED ARE DUE IN FULL AT THE TIME OF SERVICE. ULTIMATELY, THE PATIENT IS RESPONSIBLE FOR ALL CHARGES INCURRED AT PINEHURST CHIROPRACTIC.

CHILDREN UNDER 18 YEARS OLD:

1ST APPOINTMENT THERE WILL BE A $20 EXAM FEE.
THEN ANY APPOINTMENTS FOLLOWING WILL BE CHARGED $ 1 PER YEAR OF AGE

CASH*

OUR FEES FOR CASH PATIENTS: $50.00 ADJUSTMENT IF PAID AT TIME OF SERVICE INCLUDES EXTREMITIES
$65.00 IF BILLED
$60.00 NEW PATIENT EXAM
$140.00 IF BILLED
$45.00 (IF ADJUSTMENT INCLUDES ANY EXTREMITY)

PAYMENT MAY BE MADE BY CASH, CHECK, VISA, MASTERCARD OR AMERICAN EXPRESS.

MAJOR MEDICAL HEALTH INSURANCE

PINEHURST CHIROPRACTIC WILL SUBMIT CLAIMS TO THE PATIENT'S PRIMARY HEALTH INSURANCE AS LONG AS WE ARE A PREFERRED PROVIDER.

WE ARE IN NETWORK WITH THE FOLLOWING CARRIERS: REGENCE BLUE CROSS/BLUE SHIELD, PREMERA, FIRST CHOICE HEALTH, LIFEWISE, AETNA, CIGNA, UNIFORM MEDICAL, AND HEALTHWAYS WHOLEHEALTH NETWORKS

WE DO NOT BILL SECONDARY INSURANCE COMPANIES.

PERSONAL INJURY INSURANCE

PINEHURST CHIROPRACTIC WILL SUBMIT CLAIMS TO THE PATIENT'S AUTO INSURANCE COMPANY, IF THE PATIENT HAS PERSONAL INJURY PROTECTION (PIP), PROVIDED WE HAVE RECEIVED THE APPROPRAITE INFORMATION FROM THE PATIENT (INS. CO. NAME, BILLING ADDRESS, CLAIM NUMBER, AND ADJUSTER'S NAME). IF THERE ARE NO BENEFITS, THE PATIENT IS RESPONSIBLE FOR ANY AND ALL COSTS ACCRUED.

LABOR AND INDUSTRIES

PINEHURST CHIROPRACTIC WILL SUBMIT ALL CLAIMS TO THE DEPARTMENT OF LABOR AND INDUSTRIES, OR THE APPROPRIATE SELF INSURED COMPANY. IF THE CLAIM IS REJECTED, THE PATIENT IS RESPONSIBLE FOR THE BALANCE.

MEDICARE*

PINEHURST CHIROPRACTIC WILL SUBMIT CLAIMS TO MEDICARE, BUT YOU MUST PAY AT THE TIME OF SERVICE AS WE DO NOT RECEIVE PAYMENT FROM MEDICARE.

WE CANNOT GUARANTEE REIMBURSEMENT.

MEDICARE FEES: $27.55 1-2 REGION ADJUSTMENT
$38.17 3-4 REGION ADJUSTMENT
$50.00 EXAM NOT PAID BY MEDICARE

MEDICARE ONLY REIMBURSES FOR ACUTE CONDITIONS, THEY WILL NOT REIMBURSE FOR MAINTENANCE

IN ALL FAIRNESS TO OTHER PATIENTS, WE REQUIRE A 24 HOUR NOTICE OF CANCELLATION. **THERE WILL BE A $35.00 CHARGE FOR CANCELLATIONS WHICH OCCUR LESS THAN 24 HOURS IN ADVANCE OF YOUR SCHEDULED APPOINTMENT TIME,** AS WELL AS NOT SHOWING UP FOR YOUR SCHEDULED APPOINTMENT TIME. THANK YOU FOR YOUR CONSIDERATION.

I, _____, HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE FINANCIAL POLICY, AND KNOW THAT I AM UNLTIMATELY FULLY RESPONSIBLE FOR PAYMENT OF MY BILL FOR SERVICES RENDERED AT PINEHURST CHIROPRACTIC.

YOUR SIGNATURE BELOW ALSO AUTHORIZES US TO RELEASE ANY PERSONAL AND MEDICAL INFORMATION NECESSARY TO PROCESS YOUR INSURANCE CLAIMS.

PATIENT SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____

*** PRICES SUBJECT TO CHANGE**