AGLA
Chiropractic
Ease for all ages & stages of life!

Claim#: _____
Clinic: 1707 S 341st Pl Ste A, Federal Way, WA 98003
Mail: P.O. Box 23955, Federal Way, WA 98093
Phone: (253) 632-5320 Fax: (253) 214-7444
www.AGLAchiro.com

PATIENT INTRODUCTION FORM

How did you hear about our office? _____

Patient's Personal Information: Sex: □ M □ F Date of Birth:_____

Full Legal Name:_____ _____ _____
Last Name *First Name* *M.Initial*

Street Address:_____
City:_____ State:_____ Zip:_____

Cell Ph#:_____ E-Mail:_____ Last 4 digits of SS#:_____

Employer:_____ Work Ph#:_____
City:_____ State:_____ Zip:_____

Marital Status: □ Single □ Married □ Other

Spouse's Name:_____ _____ _____
Last Name *First Name* *M.Initial*

Emergency Contact Information:
Name:_____ Relationship:_____
Cell Ph#:_____ Work Ph#:_____ E-Mail:_____

PRIVACY PROTECTION AND NOTIFICATIONS

Our clinic now uses video recording cameras as part of the security system in the main open areas, not the private ones. We do not record audio. It is the policy of this office to protect the patient's privacy in accordance with state and federal regulations. Patients and guests are not authorized to record/take/use any equipment for audio, video, photography, open phone lines, speakerphones, etcetera, while visiting the office without the Doctor's consent. Information regarding the patient and/or treatment will be shared only with other people as listed below who are committed to protecting the patient's privacy and only for purposes of treatment, consultation, billing and collection of payment. I authorize AGLA Chiropractic to release or obtain any information or communication pertinent to my case, my claims, my care, and my treatment to/from any insurance company, adjuster, attorney, law enforcement agency, employer, doctor, medical facility, etcetera involved in my accident/illness and authorize the above mentioned assignee to contact the employer, insurance carrier, attorney, law enforcement agency, doctor, medical facility, etcetera for the purpose of discussing my treatment or case, obtaining and sharing records, determining the existence and extent of insurance benefits and managing my health benefits payments to me and/or my practitioner; and I hereby release them of any consequence thereof. Signature below indicates that the patient has read and understands the privacy protection policy and indicates consent to share their personal information and communication as indicated and only when necessary.

APPOINTMENT CANCELLATION POLICY

Appointments that are not cancelled with at least 24-hours notice and that we are unable to fill with another patient **WILL BE charged $60.00** for the missed appointment(s) & loss of income for that scheduled time. Insurance companies cannot be billed for these missed appointments.

I have read the above Privacy Protection and Notifications and Appointment Cancellation Policy.

Date:_____ Signature:_____

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INSURANCE INFORMATION

Is your visit to our office today related to an auto accident or work related accident? □Yes □No

□ **Primary Insurance Info. (Self/Spouse,etc):** **Injury Claim#:**_____
Name of Insurance Company:_____ Phone Number:_____
Policy / Subscriber ID #:_____ Group #:_____

Subscriber's Relationship to Patient: □ Self □ Spouse □ Parent □ Other_____
Subscriber's Full Legal Name:_____ _____ _____
Last Name *First Name* *M.Initial*
Subscriber's Date of Birth:_____ Phone Number:_____
Subscriber's Street Address:_____
City:_____ State:_____ Zip:_____
Subscriber's Employer:_____
City:_____ State:_____ Zip:_____

□ **Other Party's Insurance Info:** □ **Secondary Insurance Info:** **Injury Claim#:**_____
Name of Insurance Company:_____ Phone Number:_____
Policy / Subscriber ID #:_____ Group #:_____
Subscriber's Relationship to Patient: □ Self □ Spouse □ Parent □ Other_____
Subscriber's Full Legal Name:_____ _____ _____
Last Name *First Name* *M.Initial*
Subscriber's Date of Birth:_____ Phone Number:_____
Subscriber's Street Address:_____
City:_____ State:_____ Zip:_____
Subscriber's Employer:_____
City:_____ State:_____ Zip:_____

ASSIGNMENT OF BENEFITS / FINANCIAL AGREEMENT / TEXTING AUTHORIZATION

I hereby give permanent authorization for payment of all insurance benefits to be made out directly to AGLA Chiropractic for services rendered here. If the current insurance policy prohibits direct payment to the doctor, then I hereby also instruct and direct the insurance company to make the check out to myself and AGLA Chiropractic and mail it to the clinic directly. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collections, and reasonable attorney's fees. I understand that interest will be charged at a rate of 1% per month, (12% per year), on the unpaid balance over 30 days old with a minimum charge of $ 0.50. I also understand that monthly payments are required of 20% or $ 25.00, whichever is greater. I authorize AGLA Chiropractic to release or obtain any information and communication pertinent to my case, my claims, my care and my treatment as indicated in the privacy protection section listed above and I hereby release them of any consequence thereof. I authorize AGLA Chiropractic to send text messages to my mobile phone. I understand that standard text messaging rates will apply to any text messages to/from myself and AGLA Chiropractic. I also understand that I may revoke this permission in writing at any time. I agree not to hold AGLA Chiropractic liable for any electronic messaging storage, charges or fees. I further agree that a photocopy of this agreement shall be as valid as the original.

Method of Payment: □Cash □Check □Credit/Debit Card (Visa/MC/Disc/AMEX) □Health Ins. □Auto Ins. □L&I

Date:_____ Signature:_____

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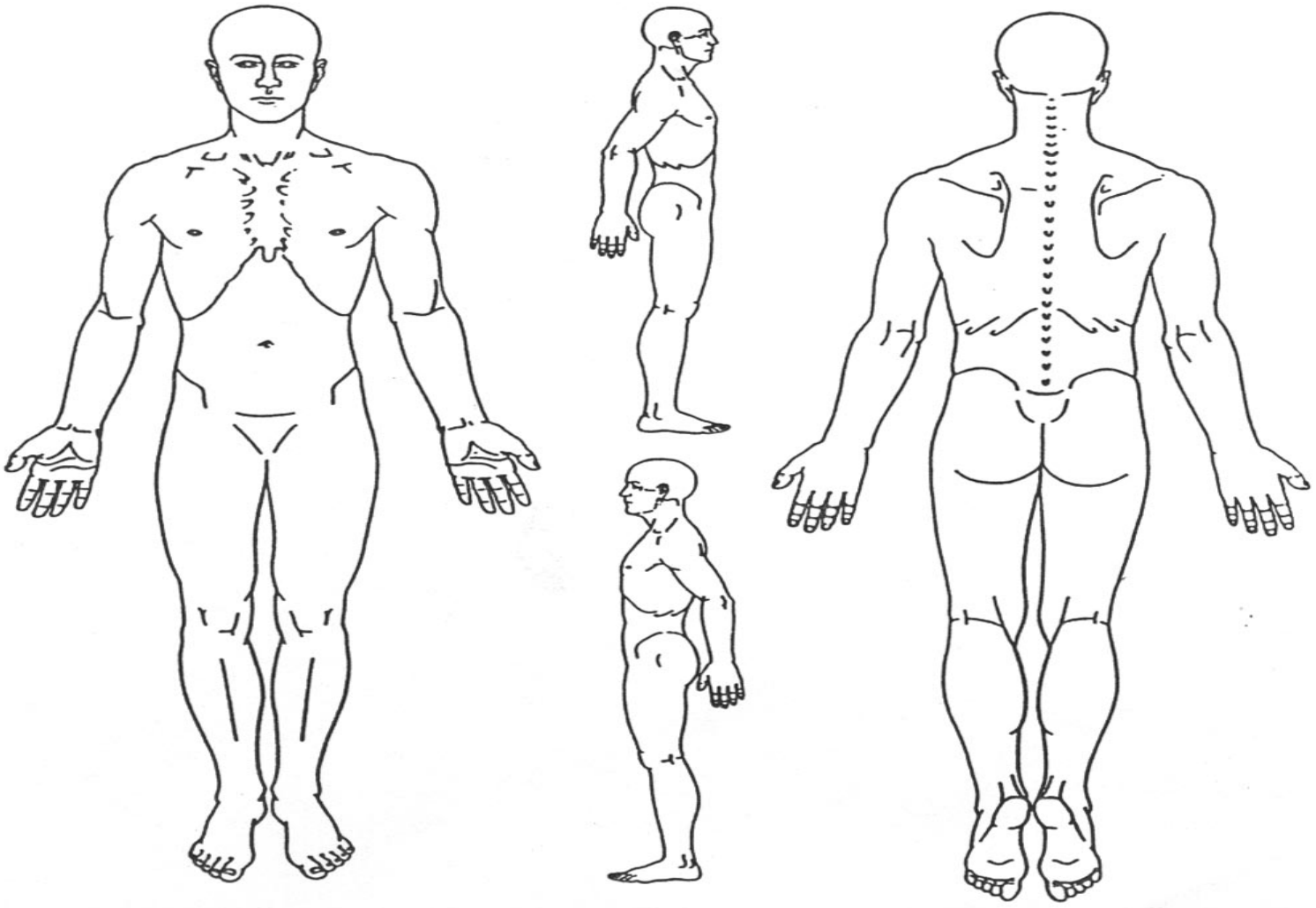
Patient Name:_____ Date:_____

What is your **maximum** pain/discomfort (without pain medications)? (**0** = No Pain **10** = Unbearable pain)

											(Details)
Headache:	0	1	2	3	4	5	6	7	8	9	10 (_____)
Neck:	0	1	2	3	4	5	6	7	8	9	10 (_____)
Upper Back:	0	1	2	3	4	5	6	7	8	9	10 (_____)
Mid Back:	0	1	2	3	4	5	6	7	8	9	10 (_____)
Lower Back:	0	1	2	3	4	5	6	7	8	9	10 (_____)
Arm/Leg:	0	1	2	3	4	5	6	7	8	9	10 (_____)

CIRCLE THE AREAS OF DISCOMFORT

(Mark to Describe: **A**=achy, **B**=burning, **C**=constant, **N**=numb, **P**=pins & needles, **S**=stabbing, **T**=throbbing, **O**=other, etc.)



How much has your condition improved since your symptoms FIRST started?

-30% -20% -10% -5% **0%** 5% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

PATIENT'S INITIALS:_____

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Patient Name:_____ Date:_____
Is your condition a result of an Auto Accident? □ YES □ NO Is it due to a Work Injury? □ YES □ NO
PRIMARY CARE PHYSICIAN: Name/Clinic:_____
Street Address:_____ Ph#:_____
City:_____ State:_____ Zip:_____

PRESENT Symptoms or Complaints

Where does it hurt?_____
How & when did it happen?_____
_____
Describe the pain, (i.e., sharp, dull, grinding, pressure, throbbing, burning, etc):_____
_____
Are there any radiations into the head, arms/hands, &/or legs/feet? Describe:_____
_____
How frequent is the pain and when do you feel it?_____
What makes it: worse?_____ better?_____
List other Doctor / s seen for this condition:_____
Are you currently taking any medication? □ YES □ NO
What kind?_____
Are you allergic to any medication? □ YES □ NO
What kind?_____

IMPORTANT **Are you Pregnant, or is it possible you are?** □ **YES** □ **NO**

PRIOR Medical HISTORY (Check any and all that apply)

□ HEADACHES / MIGRAINES	□ DISC HERNIATION	□ ASTHMA	□ CONVULSIONS / EPILEPSY
□ NECK PAIN / STIFFNESS	□ NUMBNESS & TINGLING	□ COPD	□ DIZZINESS / FATIGUE
□ SHOULDER / ARM PAIN	□ NEURITIS	□ HEART TROUBLE	□ STRESS / ANXIETY
□ WRIST / HAND TROUBLE	□ ORTHOPEDIC PROBLEMS	□ HIGH BLOOD PRESSURE	□ NERVOUS DISORDER
□ CARPAL TUNNEL	□ FRACTURES	□ HIGH CHOLESTEROL	□ CHICKEN POX / SHINGLES
□ UPPER BACK PAIN	□ BURSITIS / TENDONITIS	□ POOR CIRCULATION	□ GERMAN MEASLES
□ MID BACK PAIN	□ RHEUMATISM	□ DIABETES	□ RHEUMATIC FEVER
□ LOW BACK PAIN	□ EYE PAIN	□ ANEMIA	□ TUBERCULOSIS
□ SCIATICA	□ BLURRY VISION	□ HEPATITIS	□ MUSCULAR DYSTROPHY
□ HIP / LEG PROBLEMS	□ EAR PAIN	□ ULCERS	□ MULTIPLE SCLEROSIS
□ ANKLE / FOOT TROUBLE	□ RINGING IN EARS	□ DIGESTIVE DISORDERS	□ FIBROMYALGIA
□ ARTHRITIS / JOINT PAIN	□ SINUS TROUBLE	□ DIARRHEA/CONSTIPATION	□ CANCER
□ SCOLIOSIS	□ ALLERGIES	□ CONCUSSION	□_____

Briefly Describe:_____
_____
Have you been treated by a physician for any of these health conditions in the last year? □ YES □ NO
If so, briefly describe treatment and results: _____
_____
List any hospitalizations, surgeries & dates:_____
_____
Describe any past traumas you have experienced & dates: (car accidents, sports injuries, big slips/trips/falls, head plants, etc.)
_____
_____
When was your last chiropractic treatment and what were the results?_____

PATIENT'S INITIALS:_____