WALL FAMILY CHIROPRACTIC CENTER

Dr. Michael L. Wall, D.C.
13412 Pacific Avenue
Tacoma, WA, 98444
Office: (253) 531-5242 **Fax: 253-537-7293**

About the Patient

Name: _____

Address: _____

City: _____ State: _____ Zip:_____

Home Phone: _____ Cell Phone: _____

Best number to reach you: _____

Email: _____

Birth Date _____ Gender: Male Female

Number of children: _____

Marital Status: Single Separated Widowed Married Divorced

Employer: _____

Type of Work: _____

Work Address: _____

Work Phone: _____

Social Security: _____

Financially Responsible Party

Name: _____

Address: _____

Work Phone: _____

Home Phone: _____

Relation to Patient: _____

Insurance Information

Please Circle: Automobile Personal Health Workman's Compensation

Other (Please Specify): _____

Insurance Company: _____

Policy or Claim Number: _____

Group: _____

Insured or subscriber: _____

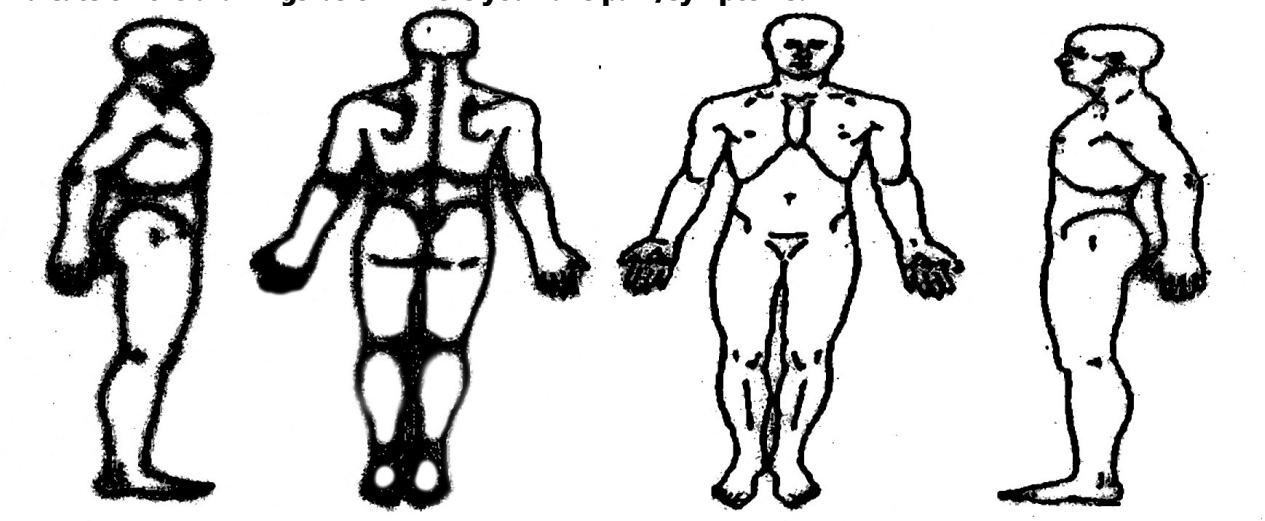
Birth Date: _____ SSN: _____

PATIENT INTAKE FORM

Patient Name:_____ **Date:** _____

1. Is today's problem caused by: Auto Accident Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms:



3. How often do you experience your symptoms?

Constantly (76% to 100% of the time) Frequently (51% to 75% of the time)

Occasionally (26% to 50% of the time) Intermittently (1%-25% of the time)

4. How would you describe the type of pain?

Sharp	Burning	Sharp with motion
Dull	Shooting	Shooting with motion
Diffuse	Numb	Stabbing with motion
Achy	Tingly	Electric with motion
Stiff	Other:_____	

5. How are your symptoms changing with time?

Getting Worse Staying the Same Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

1 2 3 4 5 6 7 8 9 10 (please circle)

7. How much has the problem interfered with your work?

Not at all A little bit Moderately Quite a bit Extremely

8. How much has the problem interfered with your social activities?

Not at all A little bit Moderately Quite a bit Extremely

9. Who else have you seen for your problem?

Chiropractor ER Physician Massage Therapist Neurologist Orthopedist Physical Therapist

Primary Care Physician No one Other:_____

10. How long have you had this problem?_____

11. How do you think your problem began?_____

12. Do you consider your problem to be severe? Yes Yes, at times No

13. What aggravates your problem?_____

_____

14. What concerns you most about your problem; what does it prevent you from doing?_____

_____

15. What's your: Height:_____ **Weight:**_____ **Age:**_____**Occupation:** _____

16. How would you rate your overall health? Excellent Very Good Good Fair Poor

17. What type of exercise do you do? Strenuous Moderate Light None

18. Indicate if you have any immediate family members with the following:

Rheumatoid Arthritis Heart Problems Diabetes Cancer Lupus ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
_____	_____	Headaches	_____	_____	High Blood Pressure	_____	_____	Diabetes
_____	_____	Neck Pain	_____	_____	Heart Attack	_____	_____	Excessive Thirst
_____	_____	Upper Back Pain	_____	_____	Chest Pain	_____	_____	Frequent Urination
_____	_____	Mid Back Pain	_____	_____	Stroke	_____	_____	Smoking/Tobacco Use
_____	_____	Lower Back Pain	_____	_____	Angina	_____	_____	Drug/Alcohol Dependence
_____	_____	Shoulder Pain	_____	_____	Kidney Stones	_____	_____	Allergies
_____	_____	Elbow/upper arm pain	_____	_____	Kidney Disorders	_____	_____	Depression
_____	_____	Wrist Pain	_____	_____	Bladder Infection	_____	_____	Systemic Lupus
_____	_____	Hand Pain	_____	_____	Painful Urination	_____	_____	Epilepsy
_____	_____	Hip Pain	_____	_____	Loss of Bladder Control	_____	_____	Dermatitis/Eczema/Rash
_____	_____	Upper Leg Pain	_____	_____	Prostate Problems	_____	_____	HIV/AIDS
Past	**Present**		**Past**	**Present**		**Past**	**Present**	

_____ _____ Knee Pain
_____ _____ Ankle/Foot Pain
_____ _____ Jaw Pain
_____ _____ Joint Pain/Stiffness
_____ _____ Arthritis
_____ _____ Rheumatoid Arthritis
_____ _____ Cancer
_____ _____ Tumor
_____ _____ Asthma
_____ _____ Chronic Sinusitis

_____ _____Abnormal Weight Gain/Loss
_____ _____ Loss of Appetite
_____ _____ Abdominal Pain
_____ _____ Ulcer
_____ _____ Hepatitis
_____ _____ Liver/Gall Bladder Disorder
_____ _____ General Fatigue
_____ _____ Muscular In-cordination
_____ _____ Visual Disturbances
_____ _____ Dizziness

For Females Only:
_____ _____ Birth Control Pills
_____ _____Hormonal Replacement
_____ _____ Pregnancy

Other:_____

20. List all prescription medication you are currently taking:_____

_____

21. List all of the over-the-counter medications you are currently taking:_____

_____

22. List all surgical procedures you have had:_____

_____

23. What activities do you do at work?

Sit:	Most of the day	Half of the day	A little of the day
Stand:	Most of the day	Half of the day	A little of the day
Computer Work:	Most of the day	Half of the day	A little of the day
On the phone:	Most of the day	Half of the day	A little of the day

24. What activities do you do outside of work?_____

_____

25. Have you ever been hospitalized? No Yes

If yes, why _____

26. Have you had significant past traumas? No Yes

If yes, why _____

27. Anything else pertinent to your visit today? _____

_____

Patient Signature: _____ **Date:**_____

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Consent for Purposes of Treatment, Payment & Healthcare Operations

I consent to the use or disclosure of my protected health information(PHI) by Wall Family Chiropractic Center for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operation of Wall Family Chiropractic Center. I understand that analysis, diagnosis or treatment of me by Wall Family Chiropractic Center may be conditioned upon my consent as evidenced by my signature below. I understand I have the right to request a restriction a to how protected health information is used or disclosed to carry out treatment, payment or health care operation of the practice. Wall Family Chiropractic Center is not required to agree to the restrictions that I may request. However, if Wall Family Chiropractic Center agrees to a restriction that I request, the restriction is binding upon Wall Family Chiropractic Center agrees I have the right to revoke this consent, in writing, at any time, except to the extent that Wall Family Chiropractic Center has taken action in reliance on this consent.

My “protect health information” means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer, or a healthcare clearing house. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have provided with a copy of the Notice of Privacy Practices Wall Family Chiropractic Center. The Notice of Privacy Practices describes the type of uses and disclosure of protected health information that will occur in treatment, payment of bills or in the performance of health care operations of Wall Family Chiropractic Center. The Notice of Privacy Practices for Wall Family Chiropractic Center is also posted in the waiting room at 13412 Pacific Avenue, Tacoma, Washington, 98444. This Notice of Privacy Practices also describes my rights and the duties of Wall Family Chiropractic Center with respect to my protected health information. Wall Family Chiropractic Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Wall Family Chiropractic Center and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

_____	_____
Signature of Patient (or Representative)	Printed Name of Patient
_____	_____
Date of Signing	Description of Representative’s Authority

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When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both to be working for the same objective. Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine.

Health: The state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer diagnosis for or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements.
(print name)
All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. Therefore I accept chiropractic care on this basis.

_____ _____
(signature) (date)

I, _____, being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual cycle._____

_____ _____
(signature) (date)

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INSURANCE AND FINANCIAL OBLIGATIONS

Please select which insurance applies to you:

_____ **PRIVATE OR GROUP INSURANCE:**
If your insurance covers your chiropractic care, you may still have to pay an annual deductible and/or co-payment. This payment is due at time of service. As a courtesy to you, we will submit your claims to your insurance company. You will be required to provide us with a current insurance card(s). You must assign benefits to this office. We do not guarantee that your insurance company will pay and we will not enter into any disputes with your insurance company. Coverage information quoted is not a guarantee of payment, but a benefit review, and final determination will be made (by your insurance company) once your claim is received.

Some insurance companies put restrictions on the number of chiropractic visits or the amount paid per year. This office does not base your care requirements on your coverage information! Your care requirements are based on diagnosis, health status and need for care. Please understand that you will often benefit from care beyond the limits of your insurance coverage.

_____ **MEDICARE:**
Our office **does not** accept Medicare assignment. You will be required to pay at the time of your visit. We **require** updated spinal x-rays, although they are not a covered service.

_____ **WORKER'S COMPENSATION:**
The Washington State Department of Labor and Industries will pay for 100% of services once your claim has been accepted. They will pay only for curative care or a point where you do not seem to make any further progress. If Labor and Industries denies your claim, you are responsible for payment of services rendered at our usual and customary rate.

If you have already seen another doctor or have already opened a claim, please be sure you have the appropriate claim number, date of injury, claim manager's name and billing information. You will be required to sign a "transfer of care" form.

Re-Opening a Closed Claim:
Your claim may be reopened if it can be determined that your present condition is a worsening of your previously accepted condition. Your first visit (exam, x-rays and adjustment) will be covered by the Department of Labor and Industries. Until we receive notification from the Department of Labor and Industries that your claim has been accepted, you will be required to pay the accepted Labor and Industries fee. If your claim is accepted, you will be refunded all fees paid by you. If your claim is denied, you will be required from that point forward to pay our usual and customary fees.

_____ **ACCIDENT (Auto, Home, Personal Injury):**
It is our office policy to bill your insurance under **PIP** (personal injury protection), **regardless of who is at fault**. **We only accept third party claims with attorney representation!**

If you have PIP, your treatment will be covered at 100% for "medically necessary" care. As a service to you, we will bill your insurance company directly. Any services or supplies not covered will become your responsibility. You must provide us with a correct claim number, billing information, telephone number, claim manager's name and attorney name (if applicable).

If you do not have PIP, you can pay for your care as follows:

1. Bill your health insurance and pay any deductibles and co-payments
2. Pay each visit**,** taking advantage of our 20% cash discount
3. Establish a monthly payment plan
4. **Pay in full at time of settlement.**

_____ **PERSONAL (No Insurance):**
Charges for all chiropractic services must be paid at time of service. We offer a 20% cash discount when fees are paid by cash or check.

My signature below acknowledges that I understand and agree to the terms of Wall Family Chiropractic Center insurance and financial obligations. I authorize direct payment to you by any insurance company for the services rendered. I authorize the release of my medical information or other information necessary to process my claims. I authorize the doctors to administer chiropractic care as they deem necessary.

_____ _____
Patient Signature Date

_____ _____
Witness Date

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THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Wall Family Chiropractic Center we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party such as insurance carrier, an HMO, a PPO, or an employer if they are or may be responsible for the payment of your services.
- Your name, address, phone number, and health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we also are permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe you intend for us to provide care.
- If we are ordered by the courts or other appropriate agency.

Any use or disclosure of your protected health information, other than outlined above, will only be made upon your written authorization. We normally provide information about your health to you in person at the time you receive chiropractic care from us. We also may mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing. We are required by the state and federal law to maintain the privacy of your patient file and the health protected information theirin. We also are required to provide you with this notice of our privacy practices with the respect to your health information. We are further required by law to abide by the terms of this notice while it is in affect. We reserve the right to alter or amend the terms of this privacy notice.

If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any changes in our privacy notice will apply for all of your information in our file. Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to this office's privacy officer, Dr. Michael Wall.

If you would like further information about our privacy policies and practices please contact Dr. Michael Wall.

This notice is effective as of January 1, 2016. This notice, and any alterations or amendments made here to will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____	_____	_____
Name (Please Print)	**Signature**	**Date**