EVERGREEN CHIROPRACTIC AND WELLNESS

Welcome to our Office

Name:_____ Home: _____ Cell: _____
Work:_____ Fax #: _____ E-Mail: _____
Address:_____City:_____State:____Zip: _____
Age:____ DOB:____ ____ ____ Social Security Number: _____Occupation: _____
Ins. Name:_____ Ins. ID#:_____
Secondary Ins. Name: _____ Ins. ID# _____
Do you have a Health Savings Account yes ☐ no ☐ or do you have a Flex Benefits program yes ☐ no ☐
Who can we thank for your referral: _____

Give a brief detailed description of the problem(s) you are currently experiencing:

_____
_____
_____
_____

How long have you had this condition? _____is it getting worse? _____
Does it affect your (check appropriate boxes): ☐ work, ☐ sleep, ☐ other: _____
Treatment received in the past: _____

Please check all your warning signs even if you are unsure if relevant to your complaint.

☐ Frequent colds ☐ Anxiety	☐ Diabetes	☐ Bed wetting	☐ Ringing in ears
☐ Cold hands/feet ☐ Ulcers	☐ Incontinence	☐ Mood swings	☐ Breathing problems
☐ Bowel problems	☐ Poor awakening	☐ Panic attacks	☐ Shoulder pain
☐ Constipation	☐ Low pain threshold	☐ Skin issues ☐ Fatigue	☐ Elbow pain
☐ Diarrhea	☐ Headaches ☐ Seizures	☐ MS ☐ Vertigo	☐ Wrist/Hand pain
☐ High BP ☐ Tight muscles	☐ Narcolepsy	☐ Thyroid issues	☐ Hip pain
☐ Heart palpitations	☐ Sleep apnea	☐ Fibromyalgia	☐ Knee pain
☐ ADD/ADHD	☐ Hot flashes	☐ Depression	☐ Ankle/foot pain
☐ Low energy	☐ Allergies	☐ Rheumatoid Arthritis	☐ Auto-immune system disorders
☐ Sinusitis	☐ IBS	☐ Chronic Fatigue Synd.	☐ Balance issues
☐ Arm/ leg weakness	☐ Sexual dysfunction	☐ TMJ (Jaw Pain)	

List current medications/Supplements:

_____
_____

List of injuries: (ex: falls, sports injuries, repetitive stress injuries)

1. _____
2. _____
3. _____
4. _____
5. _____

Have you ever been in a motor vehicle accident? (please note type and year, even if not apparently injured)
_____
Any surgeries? _____
Have you received Chiropractic care before? yes ☐ no ☐
If yes, Name of Chiropractor-Dr:_____ Location:_____
Have you received Acupuncture care before? yes ☐ no ☐ Location: _____
Have you seen a Naturopath Physician? yes ☐ no ☐ If yes, Dr._____ Location: _____

Name of Medical Provider-Dr: _____ Location: _____

Agreements

The statements made on this form are accurate, to the best of my recollection, and I agree to allow this office to do an examination of me for further evaluation.

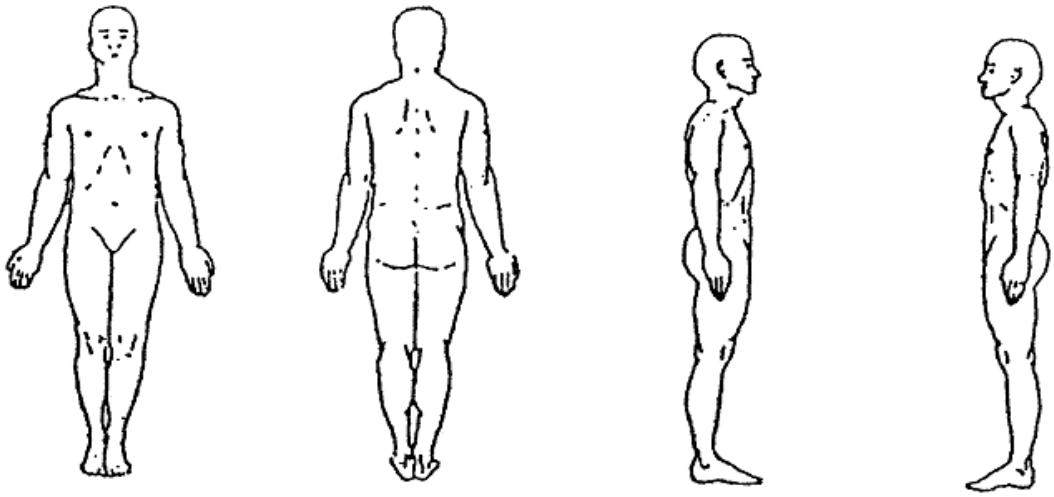
SIGNATURE_____ DATE_____

Office Use Only
O2:_____
P:_____
Ht:_____

Joint/Pain Evaluation Chart & Questionnaire

Name: _____ Date: _____

Primary Onset (check one) Chronic issue? Sports injury? Car accident? Work injury ?



Front **Back** **Right** **Left**

Indicate the location of pain / discomfort above . Use the symbol that best describes the feelings:

XXX sharp/ stabbing **PPP** pins/needles **DDD** dull/aching **NNN** numbness

? Leg pain – numbness / tingling **? Arm pain** – numbness / tingling **? Weakness** – numbness / tingling

Daily living Questionnaire

What type of work do you do? _____Hours per day? _____
Hours per day prior to pain/discomfort _____
How is your work affected? _____

Home & Family list the activities affected by your exacerbation:
_____
_____

Sleep: How many hours per night do you sleep now? _____ Prior? _____
Do you feel your sleep is affected? If yes, explain briefly:
_____

Social/Recreational: Activities _____
How are your current activities affected?: _____
_____

_____ _____
Signature Date

FAMILY MEDICAL HISTORY

F=Father M=Mother H=Husband W=Wife K=Kid(s) S=Sibling G=Grandparent

Place the appropriate letter(s) in the blank of someone in your family has/had any of the following:

_____ **Allergies** (Hay fever, Food Allergies, etc.)

_____**Anxiety**

_____**Arthritis/Joint Disease**

_____**Asthma/Breathing Problems**

_____**Bed Wetting**

_____**Bursitis** (Shoulder, Hip, etc.)

_____**Cancer** - type? _____

_____**Carpal Tunnel Syndrome**

_____**Depression**

_____**Diabetes** - type? _____

_____**Digestive Disorder** (GERD/Reflux, Ulcers, IBS, Crohn's, etc.)

_____**Ear Infections** (repetitive/chronic)

_____**Fatigue/Low Energy**

_____**Fibromyalgia**

_____ **Foot/Ankle Pain**

_____ **Headaches** (Migraines, Tension, etc.)

_____ **High Blood Pressure**

_____ **High Cholesterol**

_____ **Knee Pain**

_____ **Lower Back Pain**

_____ **Neck Pain**

_____ **Numbness/Tingling**

Where? _____

_____ **Osteoporosis**

_____ **Plantar Fasciitis**

_____ **Sciatic Pain/Sciatica**

_____ **Shoulder Pain**

_____ **TMJ/Jaw Pain**

Please check any of the following services you would like more information about:

❑ Medical Weight Loss
❑ Decompression Disc Therapy
❑ Hormone Balancing Therapy
❑ Acupuncture
❑ Migraine Therapy
❑ Massage
❑ Knee Regeneration Therapy
❑ Peripheral Neuropathy
❑ Allergy Testing

FINANCIAL POLICIES AND AGREEMENTS

(Please read, initial & sign below)

Because clarity about financial is essential for you to receive optimum benefit from you care, we have outlined our financial policies and agreements below. Please read carefully and sign or initial where indicated.

I, _____, understand and agree to the following:
(Print your name)

A. I am solely responsible for the expenses of my care and/or the care of my dependents. While I may assign payment of benefits to Evergreen Chiropractic and Wellness, any uncovered services, deductibles, and co-payments are my financial obligation, to the extent allowed by the terms of the ECW provider contracts with insurance plans. *(While most insurance plans cover chiropractic, massage, medical, naturopathic medicine your health and accident policies are a contract between you and your insurance company. We are happy to prepare any necessary reports and forms to assist you in making collection from your insurance company).*

B. **INSURANCE NON-COVERED SERVICE DISCLOSURE AND AGREEMENT**

1. Potential reasons for non-covered status include: The service is or may be deemed (a) investigational or experimental under the carrier's guidelines; (b) not medically necessary under the carrier's internal care or cost management guidelines; (c) not actually covered under the plan to which you are subscribed; (d) not provided in accordance with the Provider's Agreement with the carrier or other requirements of the carrier's or managed care entity's internal guidelines.
2. The carrier authorized the provider to charge the patient for the above services so long as this disclosure is made and signed by the patient prior to the services being provided.
3. I acknowledge that the Non-Covered status of the proposed service(s) has been explained and that a certain portion of my care may not be covered or has not been authorized by my insurance plan. If any portion of the care provided is not, or may not be covered by insurance, then I shall be responsible for payment and shall make the necessary financial arrangement with the healthcare provider to pay for these services. _____
(Initial)

C. **ASSIGNMENT AND GROUP ACCIDENT AND HEALTH INSURANCE:** *See attached form.* Any amount authorized to be paid directly to Evergreen Chiropractic and Wellness will be credited to your account upon receipt.

D. CHOICE OF PAYMENT OPTIONS: We are happy to provide the following payment options. If you are choosing to use your insurance, you will need to pick a second payment option for any service not covered by your insurance.

1. Insurance Coverage: Coverage varies with individual plans; generally, only a portion of the recommended care plan will be covered.
2. Cash/Credit per visit: Includes money orders, personal checks, credit, and debit cards; generally, a 20% discount applies
3. Payment Plans: Monthly or yearly payment plans are available with an approximate savings of 20-25%.
4. Care Credit Card/HealthCare Solutions: A zero-or-low interest healthcare credit card which you may apply for and use here in our office upon request.

Please circle your TWO choices above and initial here: _____
(Initial)

E. **AUTHORIZATION FOR TAKING AND RETAKING X-RAY FILMS:** I hereby authorize the taking of analytical x-ray films by the doctor, clinic, and/or staff of ECW, of such areas as may be of anatomical interest and which may be recommended from time to time by the doctor(s). Further, I agree that the doctor(s)/clinic shall be the sole owner of such analytical films and shall remain in custody and in control of the films, until such time as I shall see a RELEASE form stating otherwise. (*Sign signature below and initial here: _____.)* ***FEMALES ONLY****: I state that I am NOT pregnant. (Sign signature below and initial here: _____*
(Initial) *(Initial)*

_____ _____
Patient (or Parent/Guardian) Signature Date

_____ _____
Staff Signature Date

Consent for Care

(Please read, initial & sign below)

I, _____ (the patient or guardian), **grant permission to Evergreen Chiropractic and Wellness to perform examinations and procedures as may be professionally deemed necessary or advisable for me as a patient. This may include one or more of the following:**

Chiropractic adjustment: This specific application of forces to facilitate the body's correction of vertebral subluxation. Vertebral subluxation is the misalignment of nerve impulses, resulting in lessening of the body's innate ability to achieve its maximum health.

Medical/Nurse Practitioner: Practitioner at ECW provide a wide range of natural pain modalities such as Regenerative Medicine; Platelet Rich Plasma; trigger point injections and IV therapy.

Rehab Therapy: This may include rehabilitative exercises; home care stretches; Shockwave; Laser Therapy and will be performed by trained team members at Evergreen Chiropractic and Wellness.

I do not expect the doctor(s) or licensed practitioner(s) to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor(s) or licensed practitioner(s) right to exercise judgment during the course of treatment which the doctor/practitioner feels at the time, based upon the facts then known to him or her, is in my best interest. _____ (initial)

I have read the explanation above of the treatments/ services offered at ECW, I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing care and treatment. I have freely decided to undergo the recommended care and treatment, and herby give my full consent to care and treatment here. _____ (initial)

_____	_____	_____
Patient/ Responsible party signature	Printed Name	Date
_____	_____	_____
Evergreen Staff Signature	Printed Name	Date

EVERGREEN CHIROPRACTIC AND WELLNESS
Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by ECW for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of ECW.
I understand that diagnosis or treatment of me by the treating provider may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. ECW is not required to agree to the restrictions that I may request. However, if ECW agrees to a restriction that I request, the restriction is binding on ECW.
I have the right to revoke this consent, in writing, at any time, except to the extent that ECW has acted in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identities me, or there is a reasonable basis to believe the information may identify me.
I understand I have the right to review ECW Notice of Privacy Practices prior to signing this document.

Evergreen Chiropractic and Wellness Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices describes the type of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of ECW.

The Notice of Privacy Practices for all treating providers is also provided at the front desk of ECW.

This Notice of Privacy Practices also describes my rights and the duties of ECW with respect to my protected health information.

ECW 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 and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____
Signature of Patient, Guardian, or Personal Representative

_____
Name of Patient, Guardian, or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority