Baldwin
CHIROPRACTIC
Compassionate Service with Purpose

10700 SE 208th ST, Suite 207
Kent, Washington 98031
Tel: (253) 854-3185
Fax: (253)854-3185
www.BaldwinChiropractic.com

CONFIDENTIAL PATIENT INFORMATION

Date:_____ Name _____

Address _____

City _____ State _____ Zip code _____

Home Phone (___)___-_____ Cell Phone (___)___-_____ Work Phone (___)___-_____

E-mail _____ Sex: M F Other DOB: ____/_____/_____

Appointment Reminders?: (circle one) None / Email / Text Wireless Provider_____

Name of Spouse (or responsible party if minor) _____

Emergency Contact Name _____ Relationship to patient _____

Emergency Phone (_____)_____-_____ Primary Care Provider's Name _____

Primary Care Provider's Location or address _____

Smoking Status (circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

THIS OFFICE VISIT IS DUE TO

☐ Car accident ☐ On the job injury ☐ Other accident ☐ General

WHAT BROUGHT YOU IN TODAY?

1. _____ How Long? _____
2. _____ How Long? _____
3. _____ How Long? _____
4. _____ How Long? _____
5. _____ How Long? _____

Have you received other treatment for this condition? Yes / No

If yes, who _____ Where? _____

Last menstrual cycle: _____ Are you pregnant? Yes No Maybe

FAMILY HISTORY

Please note if Father, Mother, Sibling, or Off-spring have any diagnosed conditions: _____

_____

_____

_____

_____

MEDICATIONS / ALLERGIES ☐ List Provided

Medication & Dose:_____

_____

Allergies & Reaction:_____

GENERAL SYMPTOMS OR CONDITIONS

Circle all that apply

Allergies/Immune	Depression/Psychiatric	Headaches	Neurological
Arm Problems	Diabetes	Heart Conditions	Osteoporosis
Bladder Problems	Dizziness	Hip /Knee Problems	Stroke
Blood Disorders	Endocrine/Thyroid	Loss of Sleep	Skin Problems
Breathing Problems	Ear/ Nose Problems	Leg Problems	Visual Problems
Cancer	Gastrointestinal	Menstrual Problems	Other:

PERSONAL INSURANCE INFORMATION

Primary Insurance Company_____ Policy or Group _____

Name of Insured _____ Relation to Patient _____

Insurance Address:_____ Phone (_____)_____-_____

NOTICE OF THE POSSIBLITY OF INSURANCE DENIAL

Your insurance company will only pay for services it determines to be reasonable or necessary. If your insurance company determines that a particular service, although it would otherwise be covered, is not reasonable or necessary under its program standards your insurance company will deny payment for that service. The following services may not be covered: x-rays, re-examinations, supplies such as ice packs, pillows, exercise balls, orthotics, supplements, etc., Manual traction/mechanical traction, office visits, massage therapy, spinal rehabilitation exercises, trigger point.

A medical lien may be filed to help guarantee payment to Baldwin Chiropractic. A letter of Guarantee will be provided once lien has been satisfied. Interest will also be charged on accounts over 60 days past due at 6% per month.

As a courtesy to you, we will bill your insurance company directly. Please note that if we bill the insurance for your services, you **will not** be eligible for our **"paid at the time of service"** discount. This discount does not include durable medical equipment.

To take advantage of this discount, pay the discounted price at the time of service.

PRODUCT RETURN POLICY

We do not accept returns of any complimentary products purchased at Baldwin Chiropractic. This will include any pillows, supports, ice packs, nutritional supplements etc.

I have been informed by my doctor or his staff that in my case, my insurance company may deny payment for some future services. If my insurance company denies payment, I agree to be personally and fully responsible for payment of these services. I understand that I could choose to pay discounted fee at the time of service, but, at this time, would like to bill my insurance.

I authorize any person or institution providing care or services, or any organization in possession of insurance or benefit information to release any and all information pertaining to the care or benefits provided to me. I authorize payments to be made directly to Baldwin Chiropractic.

Note: Your health information will be kept confidential. Any information that we collect about you in our office will be kept confidential. If a claim is submitted to a payer, any health information attained in our office may be shared with the payer.

Patient/Spouse/Guardian Signature_____ Date _____

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ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

_____

Patient

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the Acknowledgment**
- ☐ **An emergency situation prevented us from obtaining Acknowledgment**
- ☐ **Other (Please Specify)** _____

_____

_____

Staff signature **Date**

Patient Name _____ **Date** _____

Please answer the following questions about your back pain.

1. Over the past week, on average, how would you rate your back pain?

No Pain **Worst Pain Possible**

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference **Unable to carry out activity**

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social and family activities?

No Interference **Unable to carry out activity**

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious **Extremely anxious**

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed **Extremely depressed**

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse **Have made it much worse**

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it **No control whatsoever**

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Baldwin Chiropractic
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Workers Compensation Financial Agreement

Is this claim self-insured or a state insured claim? _____

Have you already received care for this injury or opened a claim for this injury elsewhere?_____
If yes, where?_____

Patients are responsible to notify their employer that they have been injured. If you do not report your injury as required or your claim is rejected for any reason, **you will be responsible to pay for the charges incurred in our office.**

It is very important for you to follow your discussed treatment recommendations and keep your schedule appointments to achieve maximum benefit for your condition. The workers compensation law states that if you choose not to receive the care, it is necessary for your benefits to be discontinued and your case closed. If Department of Labor and Industries chooses to close your claim, it is difficult to re-open.

RE-OPENING L&I CLAIMS

***Until your case is re-opened by the State, you are responsible for payment of all bills**. We will set up a payment plan at this time. If the claim is re-opened and we receive payments you will be reimbursed.

- If a new claim, or re-opened claim is not accepted, all charges will become responsibility of the patient.

I,_____, clearly understand and agree to the terms of this financial policy.

_____ Date:_____
Patient Signature

_____ Date:_____
Witness

_____ Date:_____
Parent/Guardian Signature

Note: Any unpaid balance over 90 days is subject to a charge of 1% interest per month.

INFORMED CONSENT TO CHIROPRACTIC CARE

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae.

Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, fractures (broken rib), disc injuries, strokes, dislocations, strains, and sprains.

With respect to strokes, there is a rare but serious condition known as a cervical arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. These options may include, but are not limited to: medical care with prescription drugs, physical therapy and surgery.

Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:_____

Witness Name: _____ Signature: _____ Date:_____

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Massage Therapy Waiver

I hereby authorize massage therapy as part of my treatment in accordance with the state statues, for the care and management of my condition.

I understand and agree that health and accident insurance policies are and arrangement between an insurance carrier and me.

Some insurance policies have limitations based on medical necessity. Your licensed massage therapist is only able to treat the areas listed on the prescription provided by your healthcare provider and must provide documentation regarding your functional improvements relating to your care. **Please Note: Massage Therapy for Preventative, Maintenance or Wellness Care is NOT covered under your insurance plan.**

Medical Necessity is defined as:

- Significant, lasting therapeutic benefits leads towards a resolution of the member's complaints
- Functional limitations have improved significantly as a result of massage therapy treatment.
- Patient must have at least one functional limitation and at least one pain complaint.

Furthermore, I understand that Baldwin Chiropractic will prepare any necessary reports and forms to assist me in making collections from the insurance company, and that any amount authorized to be paid directly to Baldwin Chiropractic will be credited to my account upon receipt.

However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I have read and fully understand the above statements:

Patient Signature Date

Massage Therapy Appointment Policy

I understand that 24 hours notice is required to cancel a massage appointment at Baldwin Chiropractic.

If 24 hours notice is not given or if I do not show up for my appointment, a $30.00 missed appointment fee will be charged to the provided credit card. If I am over 7 minutes late for a massage a fee of $15 is charged to the provided credit card. If you are more than 30 min late you will be charged the full $30 fee.

I have read and fully understand the above statements:

Patient Signature Date

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EZ-Pay Authorization for Missed Massage Fee

I, _____, hereby authorize Baldwin Chiropractic to initiate debits/credit card charges and/or corrections to previous debits/charges to my account with the financial institution identified by me on this form for missing or canceling a massage within 24 hours of my scheduled massage in the amount of **$30** or Balance Due, not to exceed **$30** per transaction. The authorization is to remain in effect indefinitely and may be withdrawn by me at any time by written request.

Please Select 1 of the following methods of payment for a missed massage fee:

☐ **$30** to be placed in safe and held until such time as the above patient misses a massage, cancels within 24 hours of the appointment, or terminates services.

☐ **CREDIT CARD** on file ending in (last 4 digits) ____ ____ ____ ____ Visa® MasterCard® Discover®

Expiration date: _____/_____ Card Holder Name: _____

Card Holder Signature: _____ Date: _____

☐ If you choose to cancel your automatic payment, or changes need to be made to the account being charged, please contact: *Baldwin Chiropractic- (253)854-3185.*

☐ This authorization will remain in effect until I provide written notice revoking the authorization at least 10 days before my account is to be debited/ charged. Notice can be mailed to: Baldwin Chiropractic -10700 SE 208th Street, Suite 207 - Kent, WA 98031

Patient or Guardian Signature: _____ Date: _____