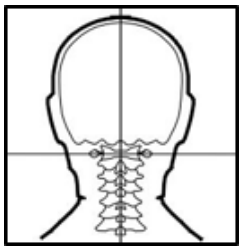


Atlas Spinal Care, P.C.

16500 SE 15th Street, Suite 160
(360) 718 - 7944 Vancouver, WA 98683 Fax (360) 718 - 7931

Patient Information

Name: _____

Address: _____

_____

Birth Date ___/___/___ **Age** ____ **Male** ___ **Female** ___

Social Sec. # ____/____/_____

Occupation _____

Employer _____

Marital Status: _____ **# of children** _____

Home # _____ **Work #** _____

Cell #_____ **Email:** _____

Best way to contact: _____

Who may we thank for referring you?

_____

Insurance

Who is responsible for this account?_____

Relationship to patient? _____

Primary Insurance Company_____

ID #_____ **Group #**_____

Primary Policy Holder _____

Birth Date _____/_____/_____

Secondary Insurance Company _____

ID #_____ **Group#** _____

Primary Policy Holder: _____

Emergency Contact

Name:_____ **Relationship**: _____

Home #_____ **Cell #**_____

Patient Condition

What is your major symptom/problem?_____

When did your symptoms begin? _____

Have you had this problem before? _____

Is your condition getting progressively worse? Yes _____ **No** _____

Is this problem: Constant _____ **Comes & Goes** _____

How does it feel? Burning ___ **Sharp** ____ **Shooting** ___ **Dull** ____ **Ache** _____

Stiff ___ **Tingling** ___ **Throbbing** ___ **Swelling** ___ **Other** _____

Circle the severity of your pain (no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

What makes your condition better? _____ **What makes your condition worse?**

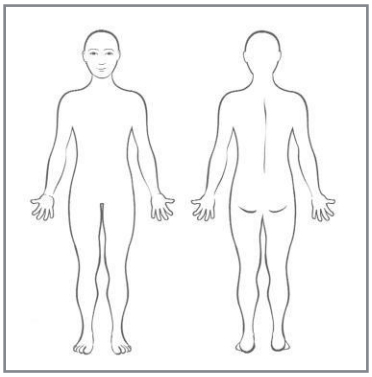
_____

Does it interfere with: Work ____ **Sleep** ___ **Daily Routine** ___ **Recreation** ___

Activities/movements that are painful to perform: Sitting ___ **Standing** ___ **Walking** ___ **Bending** ___ **Lying Down** ___

Driving ___ **Reading** ___ **Other** _____

PLEASE MARK WHERE IT HURTS



CHIROPRACTIC HEALTH HISTORY

What other treatments have you had for this condition?

__Chiropractic __ Physical Therapy __Neurologist __ Medication __ Surgery __ Orthopedic

Other:_____

Name of Doctor(s) who have treated you for this condition?_____

Date of last: Physical Exam: _____ Spinal X-ray: _____ MRI: _____ CT Scan: _____

List any allergies you currently have (food, medication, etc): _____

_____

List any medications you are currently taking: _____

_____

List any vitamins/herbs/minerals you are currently taking: _____

_____

Previous surgeries & dates: _____

Broken bones & dates: _____

Falls/Injuries & dates: _____

Circle any of the following conditions you have had:

Earache	Epilepsy/Seizures	Anxiety/Depression	Arm/Shoulder Pain
Arthritis	Asthma	Bladder Problems	Cancer
Chronic Fatigue	Deafness	Diabetes - Type 1 / Type 2	Digestion Problems
Ear Ringing	High Blood Pressure	Headaches/Migraines	Heart Disease
Hepatitis	Herniated Disc	Insomnia	Kidney Problems
Leg Pain	Neck Pain	Mid-Back Pain	Low Back Pain
Osteoporosis	Poor Circulation	Prostate Issues	Rheumatoid Arthritis

Stressors:

Smoking Packs/Day _____

Alcohol Drink/Week _____

Coffee/Caffeine drinks Cups/Day _____

Exercise:

___ None __ Moderate

___ Heavy ___# of days/week

The statements made on this form are accurate to the best of my knowledge and I agree to be examined at Atlas Spinal Care for treatment of my symptoms.

Patient Signature _____ Date _____

Atlas Spinal Care, P.C.

INFORMED CONSENT FOR CHIROPRACTIC CARE

Washington State Law requires that chiropractic patients be provided with the following information prior to being treated.

Chiropractic examination and therapeutic procedures (including spinal adjustments, muscle therapy, exercise and traction) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications include but are not limited to soreness, inflammation, soft tissue injury, dizziness and temporary worsening of symptoms. More serious complications are extremely rare.

Alternatives to chiropractic care include but are not limited to medical treatment, physical therapy, acupuncture and massage. If you have any questions, please feel free to discuss them with the doctor.

I have read, or have had read to me, the above consent. By signing below I agree to the above and allow the doctor or associates, affiliated with *Atlas Spinal Care* to perform such. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I also understand that there is no guarantee or warranty for a specific cure or result.

Patient Name (Printed) _____

Patient Signature _____ Date: _____

(Or Patient Representative) (Indicate relationship if signing for patient)

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the doctor and/or associates have my permission to perform an x-ray evaluation. I have been advised that an x-ray can be hazardous to an unborn child.

Patient Signature _____ Date: _____

Atlas Spinal Care, P.C.

OFFICE POLICIES

Please be on time for your appointment. Being late or last minute cancellations can cause severe scheduling disruptions which can interfere with the quality of care you and other patients receive.

Please do not wear strong perfumes/colognes. We see many patients with allergies or respiratory problems. Strong scents can impair their progress.

Continued cancellations or missed appointments may result in being released from care. If you need to re-schedule an appointment, please call within 24 hours of your scheduled appointment.

Children are welcome in the clinic. You are responsible for your children's actions at all times. Our staff will assist you with your well-behaved children.

We may schedule you for multiple appointments. This will help insure convenient appointment times for you as well as provide you with the highest level of care possible. If you need to spend extra time discussing your health concerns with your doctor, please let our staff know so we may schedule your next appointment accordingly. Please notify your doctor of **any** changes in your health status regardless of the significance.

FINANCIAL POLICIES

We accept the following forms of payment: Cash, Personal Checks, Debit Cards, Visa, Discover, American Express and Master Card. There will be a 3% service fee for all payments made on a credit or debit card over $1,000.

Payment is expected at the time of your visit. We will bill your primary insurance company for Initial Intensive Care as a courtesy to you. The patient is always responsible for the payment of their care. An insurance contract is between the patient and their insurance company.

Insurance coverage is never guaranteed. If there are any problems between the insurance company and the patient, the latter may file a grievance directly with your insurance company. Your signature below assigns assignment to this office for collection of benefits and also authorizes this office to release daily chart notes when necessary for the processing of claims.

The office manager may approve account balances. Active monthly payments are required. Accounts with balances 30 days past due may be charged a service fee of 12% per year compounded monthly.

Any account where no payment has been received for sixty days may be sent to a third party collection agency. Any additional collection fees will be the responsibility of the patient. NSF checks or rejected credit card payments will be charged a service fee of $35 per occurrence.

We do offer a *time of service discount* when services are paid in full at the time of the visit; however this discounted rate is no longer available once we are asked to bill any insurance.

In some cases, we may have a contract with your insurance company governing how we handle your account. This contract may prevent us from offering you our *time of service* discount. Please ask us if you have any questions.

Feel free to ask us any financial questions you may have. Our intent is to provide you with the highest level of service as well as care

Your insurance company determines benefits when they receive our billings. Any statements made by our staff regarding your coverage in no way guarantees that your care here will be covered by your insurance company and you will be responsible for your account regardless of insurance

By signing below, I acknowledge that I understand the policies as contained herein.

Patient or guardian: _____ Date: ____/____/____