EVERETT SPINE & REHAB

927 128th ST SW. SUITE B
EVERETT, WA 98204
P: (425) 347-8614
F: (425) 348-6986
www.everettspinerehab.com

MOTOR VEHICLE INJURY | OCCUPATIONAL INJURY | ORTHOPEDIC REHABILITATION

NEW PATIENT INTAKE FORM

PATIENT

Name: _____

Sex: ☐ M ☐ F Age:_____ Birth date: _____

Address: _____

_____

E-Mail Address: _____

Home Phone: _____ Work Phone: _____

Automated Message Reminder?
(You will receive an appointment reminder one day before your scheduled visit). ☐ Text ☐ E-mail ☐ Opt out

Your Employer: _____

Employer Phone: _____ Occupation: _____

Employer Address: _____

EMERGENCY CONTACT INFORMATION

Name: _____

Cell Phone: _____ Work Phone: _____

Relationship to patient: _____

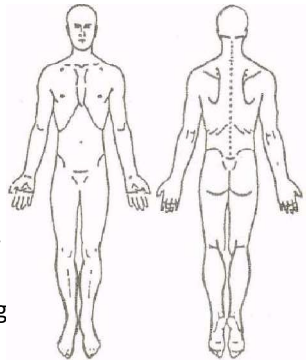
PATIENT CONDITION

Reason for visit: _____

When did your symptoms appear?_____

Is your condition getting: ☐ worse ☐ better ☐ staying same

Mark X on the picture where you have pain, numbness or tingling.



Rate your severity on a scale from:
1 (least pain) to 10 (most pain) ____

Types of pain: ☐ Sharp ☐ Dull
☐ Throbbing ☐ Numbness ☐ Achy
☐ Shooting ☐ Burning ☐ Tingling
☐ Cramping ☐ Stiffness ☐ Swelling

How often do you have pain? _____

Is your pain constant or intermittent?_____

Does it interfere with your ☐ Work ☐ Sleep ☐ Recreation
☐Other: _____

Activities or movements that are painful to perform are:
☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down

INSURANCE INFORMATION

Insurance Company: _____

Insurance ID #: _____

Group #: _____

Subscriber's Information (if different) Name: _____

Birth date: _____ SSN#: _____

Relation to patient: _____

Is patient covered by additional insurance? ☐ Yes ☐ No

If yes, which other insurance company? _____

ACCIDENT INFORMATION

Is your condition due to an accident? ☐ Y ☐ N

If yes, Date of Injury (DOI): _____

Type of accident? ☐ Auto ☐ Work ☐ Personal ☐ Other

To whom have you reported this accident to?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable): _____

Attorney Address: _____

Attorney Phone: _____ Fax: _____

PHYSICIAN & REFERRAL INFORMATION

Primary Care Physician's Name: _____ Phone #: _____ Fax #: _____

Clinic Name: _____ Address: _____

Referring Physician/Person (if different than above): _____

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HEALTH HISTORY

What treatments have you already received for your condition? ☐ Medication ☐ Surgery ☐ Chiropractic ☐ Massage ☐ PT

Name and address of other doctor(s) who have treated you for your condition: _____

_____

Date of last: Physical Exam _____ Spinal X-ray _____ Blood Test _____

Spinal Exam _____ Chest X-ray _____ Urine Test _____

Dental X-ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark "YES" or "NO" to indicate if you have or have had any of the following:

AIDS / HIV	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Thyroid Prob.	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Parkinson's Dis.	☐ Yes ☐ No	Tumor Growth	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bleeding Dis.	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Vaginal Infect.	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Venereal Dis.	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No		
Cancer	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
Cataracts	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Rheumatoid Arth.	☐ Yes ☐ No	Drug Abuse	☐ Yes ☐ No
Chicken Pox	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No	Alcohol Abuse	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Migraine	☐ Yes ☐ No	Other: _____			

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking — Packs/Day: _____
☐ Alcohol — Drinks/Week: _____
☐ Coffee/Caffeine Drinks — Cups/Day: _____
☐ High Stress Level — Reason: _____

ARE YOU PREGNANT? ☐ Yes ☐ No Due Date: _____ Name of OBGYN: _____

PRIOR INJURIES / SURGERIES

Falls: _____

Head Injuries: _____

Broken Bones: _____

Dislocations: _____

Surgeries: _____

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LIST OF MEDICATIONS	LIST OF SUPPLEMENTS	LIST OF ALLERGIES

Please list important medical conditions for each family member below:

Mother: _____

Maternal Grandparents: _____

Father: _____

Paternal Grandparents: _____

Siblings: _____

Additional Notes:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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NOTICES OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. IT ALSO DESCRIBES HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. If you have any questions about this notice, please contact our Privacy Officer at (425) 347-8614.

Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This notice applies to all of the records of your care generated by the clinic, whether made by clinic personnel or other providers involved in your care.

How We May Use and Disclose Medical Information About You

The following categories describe different ways that we use and disclose medical information. However, the usage and disclosure of your private healthcare information (PHI) is not limited to this list.

For Treatment:	We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to other healthcare providers from whom you are receiving treatment (e.g. diagnostic centers, physician's clinics, hospitals, specialists, etc.)
For Payment:	We may use and disclose medical information about you so that the treatment and services you receive at the clinic may be billed and also to receive payment from you, insurance companies, third parties, or other financially responsible parties.
Appointment Reminders:	We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the clinic. Your signature indicates your consent to receive messages and/or correspondence via the method of contacts you have given us.
Family, Caregivers, etc.:	We may release medical information about you to a caregiver who may be a friend or family member. We may also give information to someone who helps pay for your care, or whom you have identified as being involved in/responsible for your care.
As Required By Law:	We will disclose medical information about you when required to do so by federal, state or local laws.
Military:	If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.
Workers' Compensation:	We may release medical information about you for workers' compensation or similar programs, as applicable.
Public Health Risks:	We will share your health information when the law requires us to do so in the following applicable circumstances, which include but are not limited to: reporting public health threats such as infectious diseases, reporting suspected abuse, violence, or neglect victims, or to provide health information about you to protect the health and safety of yourself and others.

Your Rights Regarding Medical Information About You

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. To inspect and/or copy your personal medical information, please submit your request in writing with your signature authorizing release of information. If you request a copy of your health information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. Your request may take up to 15 business days to be fulfilled. We may deny your request to inspect and copy in certain, very limited circumstances.

Right to Amend

You may request that we correct your health information that we have created if the information is wrong or incomplete. Correction requests must be submitted in writing with an explanation of why you want the information changed. Your request may be denied if the information is correct or was not created by Everett Spine & Rehab.

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Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosures." This is a list of the disclosures we have made of medical information about you to others except for purposes of treatment, payment and operations as identified above. To request an accounting of disclosures, you must submit your request in writing to the Clinic Manager. Your request must state a time period which may not be longer than six years.

Right to Request Restrictions

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree with your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Clinic Manager. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; (3) to whom you want the limits to apply; for example: disclosures to your spouse.

Confidential Communications

You may specify where and how our staff may contact you, such as only at work or by mail. Submit your request in writing, stating how or where you wish to be contacted, including all pertinent contact information.

Changes to This Notice

We reserve the right to change this notice and to make the revised or changed notice effective for medical information we already have about you as well as information we receive in the future. When you register at the clinic, we will offer you a copy of the current notice in effect. You may request a copy of this or any future notice from the Privacy Officer.
If you believe your privacy rights have been violated, you may contact the Privacy Officer or submit your complaint in writing. If we cannot resolve your concern, you also have the right to file a written complaint with the Secretary of the Department of Health and Human Services. The quality of your care will not be jeopardized nor will you be penalized for filing a complaint.

Acknowledgement of Receipt

My signature below acknowledges that this two page Privacy Policy notice has been given to me to review and that, thereby, I have been offered and received a copy if I so desire.

Printed Name	Signature	Date

Guardian's Name (if applicable)	Signature	Date

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CONSENT TO RECEIVE CARE & ASSIGNMENT OF PAYMENTS

I hereby voluntarily consent to the rendering of examinations, diagnoses, and treatments by authorized members of the Everett Spine & Rehab staff or their designees, as deemed in their professional judgment to be necessary. I do not expect the provider to be able to anticipate and explain all risks and complications, and I wish to rely on their exercise of judgment based on the facts then known – that it is in my best interest. I understand and I am informed that in the practice of chiropractic, physical therapy, naturopathic medicine, and/or massage therapy there is a possibility, although unlikely, of adverse events from examination and/or treatment (including, but not limited to; soreness, headaches, fractures, disc injuries, strokes, bruising, flu-like symptoms, dislocations, sprains, and increased symptoms in pain or no improvement in symptoms or pain). I agree that if I suspect any adverse events that I will inform my provider.

I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatments. I also understand that my therapist cannot diagnose illnesses or prescribe medical or pharmaceutical treatments. I intend this Consent to Receive Care form to cover the entire course of treatment and my present condition as well as for any other condition(s) for which I seek treatment in the future. I understand that I may refuse treatment at any time and that I am responsible for my own healthcare choices or decisions.

I understand that payment for services rendered to me is ultimately my responsibility and that payment is due upon receipt of services unless arrangements are made in advance. I hereby instruct and direct my insurance company or their intermediaries to pay for services rendered to the providers at Everett Spine & Rehab and to be mailed at 927 128th St S.W. Suite B, Everett, WA 98204 (for the professional medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment towards the total charges for services provided). This is a direct assignment of my insurance benefits. This payment will not exceed indebtedness to the providers at Everett Spine & Rehab. I agree to cooperate with the office, and furthermore instruct my attorney to pay any balances due to this office directly at 927 128th St S.W. Suite B, Everett, WA 98204.

- I understand that the office will assess, at their discretion, a cancellation fee or charge me the full service fee if I do not give notice of cancellation of my appointment at least twenty-four hours in advancement.
- I understand there is no guarantee that my insurance companies or pre-paid health plan will cover or pay for all of my charges, and that should I fail to pay outstanding charges, Everett Spine & Rehab may opt to utilize a collection agency.
- Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all charges. A photocopy of this assignment shall be considered as effective and valid as the original document.

By signing below, I understand the terms above and agree to the Consent to Receive Care and Assignment of Payments.

Printed Name	Signature	Date

Guardian's Name (if applicable)	Signature	Date

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APPOINTMENT CANCELLATION POLICY AGREEMENT

As a multi-discipline facility, our goal is to provide quality care and to respect our patient's appointment times. If an appointment is made at Everett Spine & Rehab, our staff diligently works to manage patient schedules, provide appointment reminders to patients, and they also can establish a text message or e-mail appointment reminder option upon request. Please note: automated appointment reminders are sent out one day before your scheduled visit. If requested, patients who are frequently seen can be provided with a printout of their appointments.

Cancellation of an Appointment (24 Hour Notice Is Required)

- Please be courteous and promptly call Everett Spine & Rehab if you are unable to attend an appointment.
- Appointments are in high demand and your early cancellation will give another patient the possibility to have timely access to care.

How to Cancel Your Appointment

- To cancel appointments, please call us during our hours of operation at: 425-347-8614 | Monday through Friday | 9am-6pm.
- If you have an emergency, and are unable to reach a front desk staff member, please leave a detailed message on our voicemail system.

Late Cancellations

- Late cancellations will be considered as a "no-show".

No Show Policy Details

- A no-show patient is one who misses an appointment without providing a 24 hour notification.
- This policy will be waived in cases of emergencies (i.e. if there is adequate proof of the emergency).
- Failure to be present for a scheduled appointment will be recorded in the patient's chart as a "no-show".
- An updated address verification/phone contact form may be requested by the patient care coordinator to the patient.

No Show Policy Fees

- A $50.00 fee charge will be issued to a patient who continuously no-shows.
- Five "no shows" will result in the temporary suspension of services. In order to reinstate service, the patient will be required to meet with the Office Manager to evaluate their situation.

Walk-Ins

- We realize that illnesses and accidents often occur unexpectedly. In an effort to provide the convenience of timely care – we offer walk-in visits. Unless you have scheduled appointments, all care is provided on a first come, first serve basis.
- All emergencies will be given utmost priority.

By signing below, I understand the terms above and agree to the Appointment Cancellation Policy.

Printed Name | Signature | Date