SKAGIT RIVER CHIROPRACTIC
Confidential Patient Information

Date:_____

Name:_____ _____ DOB:_____ Age:_____ Sex: M / F

SS#:_____ Cell #:_____ Hm#:_____

Address:_____City:_____ St/zip:_____

Employer:_____ Wk #:_____

Marital Status:_____ Spouse Name:_____ Ph#:_____

Name of nearest relative or Emergency contact other than spouse:_____

Ph#:_____ Who referred you to our office?_____

_____

Present Complaint:_____

Briefly describe your symptoms:_____

List other doctor(s) seen for this condition:_____

Medical History – circle any that apply

Cancer	Muscular Dystrophy	Rheumatic Fever	Digestive Disorder
Polio	Multiple Sclerosis	Scarlet Fever	Sinus Trouble
Tuberculosis	Convulsion	Nervousness	Backaches
High Blood Pressure	Epilepsy	Asthma	Numbness
Heart Trouble	Concussions	Dizziness	Arthritis
Diabetes	Hepatitis	German measles	Venereal Disease

Describe any operations you've had and the dates:

_____

Have you been treated by a physician for any health condition in the last year? Y / N

Describe condition: _____Date of last physical exam:_____

Are you taking any medications? Y / N Please list:_____

Are you allergic to any medications: Y / N Please list: _____

Are you pregnant? Y / N Due date:_____ Date of last menstrual period:_____

(Continued on next page)

Will insurance be billed for your treatment? Y / N Insurance Name: _____

Policy #: _____ Group #: _____

ALL COPAYS ARE DUE AT THE TIME OF SERVICE

Is your visit today a result of an accident? Y / N (Example: motor vehicle, work injury, 3rd party)
If so please see receptionist for injury report paperwork.

Non-cancellation fee (without 4 hour notice) $20.00

CASH PATIENT FEE SCHEDULE
PAYMENT REQUIRED AT TIME OF SERVICE

New patient visit	**$100**	**Attended Deep Muscle therapy**	**$30**
Returning visit	**$ 40**	**15 minutes of icing**	**$25**
Extremity Adjustment	**$ 35**	**15-30 minutes of exercise training**	**$25**

X-rays may be performed based on the doctor assessment, the prices as follows:

1 view cervical	**$30**	**2 view thoracic**	**$80**
2 view cervical	**$70**	**4view thoracic**	**$120**
3 view cervical	**$90**	**2 view lumbar**	**$80**
4 view cervical	**$120**	**4 view lumbar**	**$120**
5 view cervical	**$150**	**Full spine**	**$250**

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. 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. It is my understanding that my credit may be checked if Skagit River Chiropractic extends credit to me and 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 unless prior arrangements are made. I herby authorize the doctor at Skagit River Chiropractic and whomever he or she may designate as his assistant(s) to administer treatment as they so deem necessary and also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above information is true and correct.

Print name:_____ Signature:_____

Date:_____

Skagit River Chiropractic
830 E. Fairhaven Ave
Burlington, WA 98233
Ph (360) 757-7373
Fax (360)757-6369

Notice of Privacy Practices
Patient Acknowledgement

Patient Name:_____ Date of birth: _____

I have received and understand this practice's Notice of Privacy Practices written in plain language.
The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practices legal duties with respect to my protected health information. This includes, but is not limited to:

- A statement that this practice is required by law to maintain the privacy of protected health information
- A statement that this practice is required to abide by the terms of the notice currently in effect
- Types of uses and disclosures that this practice is permitted to make for each of the following Purposes: treatment, payment, and healthcare operations
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization
- A description of uses and disclosures that are prohibited by law
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restrictions
    - The right to receive confidential communications of protected health information
    - The right to inspect and copy protected health information
    - The right to receive and accounting of disclosures of protect ted health information
    - The right to amend protected health information
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. If changes occur, this practice will provide me a revised Notice of Privacy Practices upon request.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative or parent of patient): _____

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have / have had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

CHIROPRACTOR NAME:

(Date)

PATIENT SIGNATURE X

(Or Patient Guardian/Parent/Representative) (Provide name and relationship if signing for patient)

ALSO SIGN ARBITRATION AGREEMENT ON REVERSE SIDE

SAMPLE

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, including court costs, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any such provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

	(Date)
PATIENT SIGNATURE **X**	
(Or Patient Representative)	(Indicate relationship if signing for patient)
	(Date)
OFFICE SIGNATURE **X**	

SAMPLE