Northwest Family
CHIROPRACTIC & MASSAGE

New Client Registration Form (please complete entire form)

Today's Date: _____ Primary Care Provider: _____ Phone #: _____

Client Information:

Legal Last Name: _____ Legal First Name: _____ Middle Initial: ____

Nickname: _____ Former Name: _____

Birth date: _____ Age: _____ Relationship status: single / married / divorced / separated / widowed

Gender: Male / Female Preferred Pronoun: _____ Prefer not to answer Occupation: _____

Home phone #: _____ Cell phone #: _____ Work phone #: _____

I would like text message reminders for my appointments sent to my cell phone # provided above: Yes / No

Emergency Contact: _____ Phone #: _____

Billing address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Email reminders? Yes / No

How did you hear about the office? _____

Are you covered by medical insurance? Yes / No

Does your insurance require a referral from your Primary Care Provider? Yes / No (Please ask front desk for more info if needed)

Primary Insurance: _____

Subscribers Name: _____ Subscribers date of birth: _____

Clients relationship to insurance subscriber: self / spouse / child / domestic partner / other: _____

Who is the financially responsible party for the bill? □ Self □ Other: (Please fill out below)

Name: _____ Date of birth: _____

Address: _____ City: _____ State: _____ Zip:_____

Phone Number: _____ Employer: _____

1. I understand that I am responsible for charges not covered or reimbursed by my health plan or similar payer. I agree to pay you directly if my insurer, health plan, employer program or similar benefits program does not pay.
2. I authorize my insurer, health plan, employer program or similar benefits program to release information to you regarding my coverage
3. My right to payment for care, treatment, supplies, and other services are hereby assigned to you. This assignment covers all benefits under Medicare, other government sponsored programs, insurance, employer programs and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. If my insurer, health plan, employer program or similar benefit program does not accept assignment of benefits, or if payments are made directly to me or my representative, I will endorse such payment to you.
4. I understand and authorize release of all health information about me to my insurer, health plan, employer program or similar benefits program identified above to obtain payment for care, treatment, supplies and other services. The above information is true to the best of my knowledge.

Client / Guardian Signature: _____ Date: _____

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YOUNG ADULT INFORMATION FORM (6-17 YRS)

Name: _____ Date: _____Date of birth: _____

Current Health Concern

What is the primary reason that you are seeking Chiropractic care for your child?

_____

When did it begin? _____

How did it begin? □Suddenly □ Gradually □ Following an accident

Is it getting worse? □ Yes □ No

What makes it better? _____

What makes it worse? _____

Have you ever experienced a similar condition? □ Yes □ No

Please explain: _____

Have you been cared for by another provider for this complaint? □ Yes □ No

Please explain: _____

Does it affect your daily activity? □ Not at all □ Somewhat □ Always

Which activities are affected? _____

Child Health History

Place of birth: □ Home □ Birthing Center □ Hospital

Provider: □ Midwife □ OB-Gyn □ Other

Type of birth: □ Vaginal □ Cesareans

List any food/environmental allergies: _____

Does your child have regular bowel movements? □ Yes □ No

List any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime. Include the year:

_____

_____

List any major hospitalizations or surgeries your child has experienced. Include the year:

_____

Has your child ever been checked for vertebral subluxations? □ Yes □ No □ I don't know

Are there any of the following symptoms present?

Stomach pains	Allergies	Repeated colds
Hyperactivity	Growing pains	Digestion
Leg/Knee pains	Headaches/Migraines	General Fatigue
Scoliosis	Seizures	Acne/ Skin problems
Learning difficulties	Infections	Depression
Low energy	Tonsillitis	Menstrual cramps
Asthma	Diarrhea	Anxiety
Irritability/Moodiness	Constipation	Excessive hunger
Low self-esteem	Sleeping Problems	Autism

Other: _____

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Name: _____ DOB: _____ Todays Date: _____

Please check any boxes that apply to your health, past or current.

General-
□ Weight loss or gain
□ Fatigue
□ Fever or chills
□ Weakness
□ Trouble sleeping

Skin-
□ Rashes
□ Lumps
□ Itching
□ Dryness
□ Color changes
□ Hair and nail changes

Head-
□ Headache
□ Head injury
□ Neck Pain

Ears-
□ Decreased hearing
□ Ringing in ears
□ Earache
□ Drainage

Eyes-
□ Vision Loss/Changes
□ Glasses or contacts
□ Pain
□ Redness
□ Blurry or double vision
□ Flashing lights
□ Specks
□ Glaucoma
□ Cataracts
□ Last eye exam: _____

Nose-
□ Stuffiness
□ Discharge
□ Itching
□ Hay fever
□ Nosebleeds
□ Sinus pain

Throat-
□ Bleeding
□ Dentures
□ Sore tongue
□ Dry mouth
□ Sore throat
□ Hoarseness
□ Thrush
□ Non-healing sores

Neck-
□ Lumps
□ Swollen glands
□ Pain
□ Stiffness

Respiratory-
□ Cough
□ Sputum
□ Coughing up blood
□ Shortness of breath
□ Wheezing
□ Painful breathing

Cardiovascular-
□ Chest pain or discomfort
□ Tightness
□ Palpitations
□ Shortness of breath with activity
□ Difficulty breathing lying down
□ Swelling
□ Sudden awakening from sleep with shortness of breath

Gastrointestinal-
□ Swallowing difficulties
□ Heartburn
□ Change in appetite
□ Nausea
□ Change in bowel habits
□ Rectal bleeding
□ Constipation
□ Diarrhea
□Yellow eyes or skin

Urinary-
□ Change in frequency
□ Change in urgency
□ Burning or pain
□ Blood in urine
□ Incontinence
□ Change in urinary strength

Vascular-
□ Calf pain with walking
□ Leg cramping

Musculoskeletal-
□ Muscle or joint pain
□ Stiffness
□ Back pain
□ Redness of joints
□ Swelling of joints
□ Trauma

Neurologic-
□ Dizziness
□ Fainting
□ Seizures
□ Weakness
□ Numbness
□ Tingling
□ Tremor

Hematologic-
□ Ease of bruising
□ Ease of bleeding

Endocrine-
□ Head or cold intolerance
□ Sweating
□ Frequent urination
□ Thirst
□ Change in appetite

Psychiatric-
□ Nervousness
□ Stress
□ Depression
□ Memory loss

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Chemical Stressors

Has your child been vaccinated? □ Yes □ No
Reason: □ Informed decision □ Recommended □ Did not know I had a choice
Did your child have any negative reaction to the vaccines? □ Yes □ No
If yes, were they reported? □ Yes □ No
Has your child been on antibiotics? □ Yes □ No
If yes, how often and what purpose? _____
Is your child currently taking any medication? □ Yes □ No
If yes, how often and what purpose? _____
Is your child currently taking any vitamins? □ Yes □ No
If yes, please list: _____
How many glasses does your child drink per day? Water ____ Milk ____ Juice ____ Soda ____
Does your child consume artificial sweeteners? □ Yes □ No
Rate your child's diet: □ Well-balanced □ Average □ High sugar/ processed foods
What is your favorite food? _____
Is there anything else the Doctor should know?
_____
_____
Have you, the child's legal guardian, had any personal experience with Chiropractic? □Yes □No

Authorization to evaluate and care for a Minor

I, _____ the undersigning parent/ guardian having legal custody/ guardianship of _____, a minor, do herby authorize, request, and direct the staff and doctors of Northwest Family Chiropractic & Massage to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary.

Printed Clients Name: _____

Signature of legal parent/guardian of client: _____

Our Mission is to provide a profound health care experience in a professional and genuine environment. We empower our clients through individualized Chiropractic programs and lifestyle coaching and inspire our clients to uncover the natural healing power from within.

Welcome to NW Family Chiropractic & Massage

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FINANCIAL ATTENDANCE & HIPAA DISCLOSURE

Claims Escalation to the Washington State Office of the Insurance Commissioner

In the event of an unreasonable claim denial, unresolvable claims issue, or claim decision that could be a violation of state law; it is possible to escalate claims issues to the Washington State Office of the Insurance Commissioner. In order to solve the issue, the Insurance Commissioner's office does require the patient's name, ID and/or group number, DOB, explanation of benefits, and possible discussion of any claims related communication between the patient, our office, and the insurance carrier.

Please choose from the following options:

- ☐ **Option 1:**
  I give NW Family Chiropractic permission to release my information, as specified above, to the Office of the Insurance Commissioner; in order to resolve claims issues as they deem appropriate.
- ☐ **Option 2:**
  I may release my information to the Office of the Insurance Commissioner but only on a case-by-case basis. Please seek my written approval for any applicable claims issue.
- ☐ **Option 3:**
  Under no circumstances do I wish for NW Family Chiropractic to release my information to the Office of the Washington State Insurance Commissioner.

The insurance commissioner does not regulate out of state or self-funded health plans.

RELEASE OF PERSONAL INFORMATION

Please initial: _____

I authorize the release of my information to the following individual (s)

☐ Self only
☐ Other (please write in below)

Name: _____ Relationship: _____ Phone #: _____
Name: _____ Relationship: _____ Phone #: _____

MISSED APPOINTMENT FEES

We allocate a specific time for your appointment to better fit your needs. We understand that there may be times when you must cancel or reschedule an appointment, but we do request advance notice for the following services:

24 hours advance notice is required to cancel or change a **massage** or incur a **$70.00** missed appointment fee.

Notice **ahead of the scheduled time** to cancel or change a **chiropractic** appointment or incur a **$20.00** missed appointment fee.

Missed appointment fees may not be billed to insurance. **Please initial:** _____

NOTICE OF PRIVACY PRACTICES

I have read the privacy notice & understand my rights. I authorize NW Family Chiropractic to use and disclose my protected health information for the purpose of treatment, payment, and healthcare operations as described in the privacy notice. If you have questions about any part of this notice or want more information about your privacy rights, please contact Marisa De Lisle DC, at 206-363-4478 within 2 working days. If you are not satisfied with the manner that this office handles your complaint, you may submit a formal complaint to: DHHS, Office of Civil Rights.

Patient Name: _____ **Patient Signature:** _____ **Date:** _____

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Insurance Verification Form

Patient Name: _____ Effective date:_____

Insurer: _____ Insurer Date of birth:_____

Insurance Company Name: _____

Do you have a Secondary Insurance Company? _____

Dear Practice member. This form is provided for you to document your Insurance Benefits. Over the years there have been many changes in the insurance world, because of that, we ask that you verify your benefit information, so you understand how your benefits work.

Please verify this information regarding your Chiropractic Benefit:

Spinal Manipulation: # per year_____

Plan Deductible: _____

(Does the deductible apply to the spinal manipulation visits? YES / NO)

Co-Pay per visit: $_____

Co-Insurance %: _____

Massage Therapy Benefit: _____ Combined with PT: Yes / No_____

<u>Regence plans</u>: do you need pre-certification for spinal manipulations? YES / NO

<u>Premera plans</u>: do you need pre-certification for PT/MT benefits? YES / NO

Some policies will process services from different benefits within the plan. If you would like to have more in depth information regarding your plan, we advise that you verify the following:

X-ray Benefit: _____

Examination Benefit: _____

Do any of these benefits apply to deductible? Yes / No _____

If you would like more information about codes we use in office, please ask front desk.

After verifying this information, please provide this to the front desk staff