PROSPORT+SPINE
CHIROPRACTIC • SPORTS REHAB • MASSAGE

1 PATIENT INFORMATION

Patient Name _____ Date _____
Last First (Legal) (MI) Nickname

Date of Birth: _____ / ____ / _____ Age: _____ ❑ M ❑ F Social Security # : _____ - _____ - _____

❑ Married ❑ Widowed ❑ Single ❑ Divorced ❑ Partnered ❑ Minor

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

Home Phone: _____ Cell: _____ E-Mail: _____

Would you like Appointment/E-Mailed Reminders sent to you? ❑ Yes ❑ No

Parents Name: _____ Date of Birth: _____ / ____ / _____ Employer: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

What treatment have you already received for your condition? ❑ Medications ❑ Surgery ❑ Physical Therapy ❑ Chiropractic Services ❑ None ❑ Other:_____

Whom may we thank for referring you: _____Who is your primary care physician? _____

Payment will be made by: ❑ Cash ❑ Credit Card ❑ Health Insurance ❑ Auto Insurance❑ Other _____

2 INSURANCE INFORMATION

Do you have health insurance? ❑ Yes ❑ No Subscriber's DOB:_____

Company Name: _____

Group # _____ Policy/ID # _____

Are you covered by more than one insurance company? ❑ No ❑ Yes, Please list below:

Company Name: _____

Group # _____ Policy/ID # _____

Person Responsible for Account: _____ Relationship: _____

Address *(if different from above)*: _____

Is today's visit due to a: Work Related Injury? ❑ Auto Accident? ❑ Date Of Injury: _____
Have you submitted an L&I "Report of Accident" Form? ❑ No ❑ Yes, Claim Number:_____
(If yes to either questions above, please check with receptionist, additional information is needed)

3 ASSIGNMENT OF BENEFITS

Your signature is necessary for us to process any insurance claims and to ensure payment of services rendered. I authorize release of all medical information necessary to process my insurance, workman's compensation or personal injury claims that is pertinent to my medical care. I assign all medical benefits to which I am entitled to the above named physician or clinic. This agreement will remain in effect until all money owed to the above named physician or clinic is paid in full. In

addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this state of Washington. **I UNDERSTAND THAT I AM FINANCIALLY REPSONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.**

Patient or Responsible Party Signature: _____ ***Date:*** _____

4 PATIENT CONDITION

Reason for visit and goals for seeking treatment? _____

_____

When and How did this begin? _____

Have you ever had a metal implant?❑ No ❑ Yes, Location?_____

Mark with an "**X**" on the diagram where you have symptoms:

Rate the severity of your pain on a scale from **1** *(least)* to **10** *(severe)*: _____

Type of pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting ❑ Burning

❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other:_____

How often do you have these symptoms? _____

Is your condition getting progressively worse? ❑ Yes ❑ No ❑ Unknown

Is it constant or does it come and go? _____

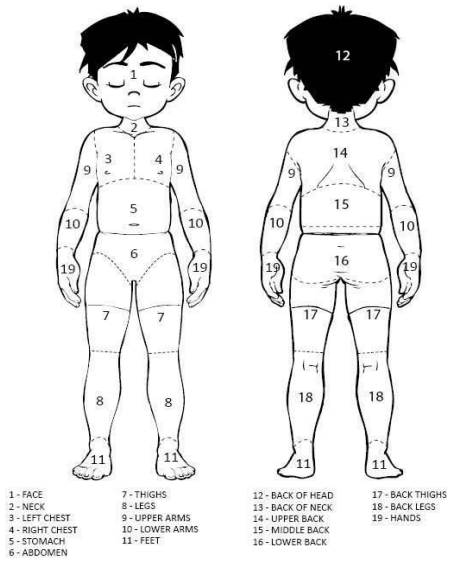
How long have your symptoms persisted for? ❑ ___Hour(s) ❑ ___Day(s) ❑ ___Weeks(s) ❑ ___Month(s) ❑ ____Year(s)

Have you had this condition/injury before? ❑ No ❑ Yes, When?_____

Does it interfere with your ❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation

Activities or movements that are painful to perform ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down

Imagine this picture is your body. Can you color the area that is hurting you right now?



5 HEALTH HISTORY

Please list the Doctor(s)or Clinic(s) you have seen for your condition:_____

_____

Please list the Medications/ Vitamins/ Minerals you are currently taking:_____

_____

Are you allergic to any Medications? ❑ No ❑ Yes if yes, which ones:_____

Are you allergic to any other products/foods? ❑ No ❑ Yes if yes, which ones:_____

Please mark indicate if you have had any of the following:

Acid Reflux	❑	Chicken Pox	❑	Hip Dysplasia	❑	Posture Imbal.	❑	Thyroid Problems	❑
ADD/ADHD	❑	Colic	❑	Kidney Disease	❑	Prosthesis	❑	Tonsillitis	❑
Acid Reflux	❑	Const/Diarrhea	❑	Learning Difficulty	❑	Psychiatric Care	❑	Torticollis	❑
Allergies	❑	Diabetes	❑	Liver Disease	❑	Rashes/Eczema	❑	Tuberculosis	❑
Anemia	❑	Digestive Prob.	❑	Measles	❑	Rheumatic Fever	❑	Tumors/Growths	❑
Autism	❑	Ear Infections	❑	Migraine/Headache	❑	Scarlet Fever	❑	Typhoid Fever	❑

Appendicitis	❑	Epilepsy	❑	Mononucleosis	❑	Scoliosis	❑	Ulcers	❑
Asthma	❑	Fractures	❑	Multiple Sclerosis	❑	Sinus Problems	❑	Whooping C.	❑
Bed Wetting	❑	Frequent Fevers	❑	Mumps	❑	Seizures	❑	Other:	
Bleeding Dis.	❑	Growing Pains	❑	Pinched Nerve	❑	Sleep Problems	❑	_____	
Bronchitis	❑	Heart Disease	❑	Pneumonia	❑	Stroke	❑	_____	
Cancer	❑	Hepatitis	❑	Polio	❑	Tip Toe Walk	❑	_____	

General/Pre-Natal History

Any Pregnancy complications? ❑ No ❑ Yes if yes, explain:_____
Medications taken during pregnancy? ❑ No ❑ Yes if yes, explain:_____
Cigarettes or alcohol during pregnancy? ❑ No ❑ Yes if yes, explain:_____
Birth Interventions? Forceps Vacuum C-section
Complications during delivery? ❑ No ❑ Yes if yes, explain:_____
Location of Birth: Home Hospital Birth Center Other:_____ Length of Labor:_____
Medications during labor/delivery?_____
Genetic disorders or disabilities? ❑ No ❑ Yes if yes, explain:_____
Has your child been prescribed any antibiotics? ❑ No ❑ Yes if yes, when and how many:_____
Has your child received any vaccinations? ❑ No ❑ Yes if yes, which ones:_____
_____
How many weeks gestation was the baby at birth?_____ Weight:_____ Height:_____

Feeding History

Breast fed? ❑ No ❑ Yes if yes, how long?_____ Formula Fed? ❑ No ❑ Yes if yes, how long_____
Introduced to solids at_____ months Cows milk _____months Grains/cereal _____months
Food Allergies/Intolerances? ❑ No ❑ Yes if yes, explain:_____

Childhood Diseases

Chicken Pox: ❑ No ❑ Yes Age:_____
Rubella: ❑ No ❑ Yes Age:_____
Whooping Cough: ❑ No ❑ Yes Age:_____
Rubeola: ❑ No ❑ Yes Age:_____
Mumps: ❑ No ❑ Yes Age:_____
Other: ❑ No ❑ Yes Age:_____

Developmental History

At what age was your child able to respond to/ do the following:

_____Sound _____Hold head up alone _____Cross Crawl

_____Visual Stimuli _____Sit up alone _____Stand Alone

_____Walk Alone _____Feed themselves _____Roll over on own

Has your child had any major falls, injuries or other emergency type accidents? ❑ No ❑ Yes if yes, explain:
_____

Is your child currently or have they been involved in athletics? ❑ No ❑ Yes if yes, explain:
_____

Has your child had any surgeries? ❑ No ❑ Yes if yes, explain:_____

How would you rate your child's diet? Well balanced average high sugar picky eater
Sleep habits: _____ hours per night _____hours per day/naps Sleep Quality: Good Fair Poor

Has your child had any imaging taken? (xray/mri/ct etc) ❑ No ❑ Yes if yes, explain:_____

Did your child spend a lot of time in any baby devices? (bouncy seats, swings, bumbos, etc.?) ❑ No ❑ Yes
if yes, which ones:_____

What position does your child sleep in most often?_____

6 CANCELLATION AND NO-SHOW POLICY:

We take this subject very seriously as this can make a difference between responding to treatment or not. We require a 24 hour notice in the event of a cancellation. **There is a $50 charge for a cancellation or no-show** without proper notice. For worker's compensation and personal injury cases, documentation of any missed appointment is forwarded to your case manager and/or primary physician. This charge will not be covered by your insurance, worker's compensation or personal injury cases, and **IS YOUR RESPONSIBILITY**.

INFORMED CONSENT:

Medical doctors, chiropractic doctors, osteopaths, and physical therapists that perform manipulation are required by law to obtain your informed consent before starting treatment.

I _____, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used. Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor. Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including, rest, home applications of therapy, prescription or over-the counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/ adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

Webster Technique: I understand that the Webster Technique is a specific chiropractic analysis and diversified adjustment. The goal of the adjustment is to reduce the effects of a sacroiliac joint dysfunction. In doing so neuro-biomechanical function in the pelvis is improved. It is not a treatment of the child in any way, nor will there be any treatment done to the unborn child. As it is out of the scope of chiropractic practice.
X_____Initial

_____*I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction* ***PRIOR TO MY SIGNING THIS CONSENT FORM****. I have made my decision voluntarily and freely.*

_____ **Signature of Patient** **Date** _____

_____ **Signature of Parent/Guardian (if a minor)** **Date** _____

_____ **Signature of Witness** **Date** _____

STATEMENT OF FINANCIAL LIABILITY:

I understand that I am fully responsible for the payment of this account, and hereby assume and guarantee prompt payment of all expenses incurred. I understand that I am responsible for payment of office charges **AT THE TIME OF SERVICE**.

I understand that unless otherwise indicated below, I hereby request and authorize Pro. Sport + Spine Clinic/ Dr. Spaulding/ Dr. Hartford to bill my insurance policy/policies for all services provided to me. I authorize payment to Pro. Sport + Spine Clinic/ Dr. Spaulding/ Dr. Hartford for all such services. I acknowledge that the fees charged by Pro. Sport + Spine Clinic/ Dr. Spaulding/ Dr. Hartford are considered to fall within the "usual, customary and reasonable" range by most insurance companies. Since your policy is an agreement between you and your insurer, Pro. Sport + Spine Clinic/ Dr. Spaulding/ Dr. Hartford will not enter into any dispute between you and your insurance company. When you begin treatment with Pro. Sport + Spine, our billing department will call your insurance company to verify that you do have valid insurance coverage. However, that verification is only a confirmation of a valid policy and not a guarantee of coverage.

NOTICE OF LIABILITY FOR "NON-COVERED" SERVICES:

I understand that my insurance carrier or Medicare may deny payment or consider some or all services performed by Pro. Sport + Spine Clinic/ Dr. Spaulding/ Dr. Hartford to be "non-covered" and I am fully responsible for payment of all such "non-covered" services.

ALTERNATE BILLING / PAYMENT INSTRUCTIONS:

❑ By checking the box to the left, I hereby direct Pro. Sport + Spine Clinic/ Dr. Spaulding/ Dr. Hartford SHALL NOT bill my insurance company for services provided to me and instead I agree to pay all fees for services furnished to me. I further understand and agree that I will be required to provide a down payment prior to receiving the services based on my estimated financial responsibility.

PERMISSION TO RELEASE MEDICAL INFORMATION (HIPPA ACKNOWLEDGEMENT):

I authorize Pro. Sport + Spine Clinic/ Dr. Spaulding/ Dr. Hartford/Dr. Ball to release information from my medical record or from the person for whom I am legally responsible, to my/their insurance company, other third party payers or their reviewing agencies, as reasonably necessary to expedite claim processing. This authorization is valid for every visit to Pro. Sport + Spine Clinic/ Dr. Spaulding/ Dr. Hartford until written notice revoking it is provided. I release Pro. Sport + Spine Clinic/ Dr. Spaulding/ Dr. Hartford of all responsibility or liability for loss of confidentiality through access and/or copies of records release, or other information disclosed in compliance with this authorization.

I have read all of the above and understand/agree to all provisions therein regarding responsibility for payments and release of information.

Patient's Name: _____

Patient or Legal Guardian's Signature: _____ **Date:** _____

If Legal Guardian, Relationship to Patient: _____