



# New Patient Packet

**ABOUT THE PATIENT** (side 1)

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Birth date \_\_\_\_\_  
Age \_\_\_\_\_ Gender  M  F Number of Children \_\_\_\_\_  
Employer \_\_\_\_\_  
Work Address \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Type of Work \_\_\_\_\_  
Marital Status  Married  Single  Divorced  
 Separated  Widowed  
E-Mail Address \_\_\_\_\_

**ABOUT THE SPOUSE [or Parent if patient is child]**

Name \_\_\_\_\_  
Employer \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Type of Work \_\_\_\_\_

**REASON FOR THIS VISIT**

Describe the purpose of this visit \_\_\_\_\_  
\_\_\_\_\_

Is the purpose of this visit related to  
 Job  Sport  Auto  Fall  Other  
 Chronic Discomfort  Home Injury

Please explain \_\_\_\_\_

If job related, have you made a report of your accident to your employer?  Yes  No

When did this condition begin? \_\_\_\_\_

Has this condition  gotten worse  gotten better  
 stayed the same

Does this condition interfere with:  
 Work  Sleep  Daily Routine  Other Activities

Explain \_\_\_\_\_

Has this condition occurred before?  Yes  No

Explain \_\_\_\_\_

Have you seen other doctors for this condition?  
 Yes  No

Dr.'s Name(s) \_\_\_\_\_

Type of treatment \_\_\_\_\_

Results \_\_\_\_\_

**EXPERIENCE WITH CHIROPRACTIC**

Who referred you to this office? \_\_\_\_\_  
Have you been adjusted by a Chiropractor before?  Yes  No  
Reason for those visits? \_\_\_\_\_  
Doctor's name \_\_\_\_\_  
Approximate date of last visit \_\_\_\_\_  
Has any adult in your family seen a Chiropractor?  Yes  No  
Has any child in your family seen a Chiropractor?  Yes  No

**GOALS FOR MY CARE**

People see Chiropractors for different reasons. Some people may simply want pain relief, while others come to correct the cause of the pain. Please check the type of care you desire.

- Relief care – relief of symptoms
- Corrective care – relieving symptoms AND correcting the cause of the problem
- Comprehensive care – bring my spine and nervous system to the highest point of health possible with Chiropractic care.
- I want the Doctor to select the type of care appropriate for my condition.

\_\_\_\_\_  
Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

**MEDICATIONS**

- Nerve Pills  Stimulants
- Pain Killers (including  Blood Thinners  
Aspirin, Ibuprofen, etc)  \_\_\_\_\_
- Muscle Relaxers  \_\_\_\_\_
- Blood Pressure Medicine
- Insulin  \_\_\_\_\_

**HEALTH HABITS**

- No Yes
- Do you smoke!   \_\_\_ packs/day
- Do you drink alcohol?   \_\_\_ drinks/day
- Do you drink coffee?   \_\_\_ cups/day
- Do you exercise regularly?  No  Moderate  Daily
- Do you wear  Heel Lifts  Sole Lifts  
 Inner Soles  Arch Supports

**EMERGENCY CONTACT**

Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Home Phone \_\_\_\_\_



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## **TERMS OF ACCEPTANCE**

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal...detection and correction of vertebral subluxation. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

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***Vertebral Subluxation:*** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulse, resulting in lessening of the body's innate ability to express its maximum health potential

***Adjustment:*** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

***Health:*** A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

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We do not offer to diagnose or treat any disease condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to cure it or offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our method is specific adjusting to correct vertebral subluxations.

I, \_\_\_\_\_ have read and fully understand the above statements.  
[Print name]

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis:

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[Signature]

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[Date]



Dr. Doug Smith  
**Chiropractor**

Spinal Health Care Center

1386 SE Lund Ave., Ste. #1, Port Orchard, WA 98366

Phone (360) 874-7494 Fax (360) 874-0586

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**AUTHORIZATION FOR CHIROPRACTIC CARE**

I, the undersigned, a patient in this office hereby authorize Dr. Smith (and whomever he may designate as his assistants) to administer such treatment as is necessary, and to perform the following therapy and manipulation and such additional therapy or procedure as are considered therapeutically necessary on the basis of findings during the course of said treatment.

I hereby certify that I have read and fully understand the above authorization for chiropractic treatments, the reason why the above named treatment is necessary, its advantages and possible complications, if any, as well as possible alternative modes of treatment, which were explained to me by Dr. Smith.

I also certify that no guarantee or assurance has been made as to the results that may be obtained.

DATE: \_\_\_\_\_

SIGNED: \_\_\_\_\_

SIGNATURE OF PARENT or GUARDIAN (if minor)

\_\_\_\_\_ DATE: \_\_\_\_\_

WITNESS: \_\_\_\_\_

## **X-RAY CONSENT FORM**

### **PATIENT CONSENT TO X-RAY**

I authorize the performance of diagnostic x-ray examination of myself which Dr. Smith may consider necessary or advisable in the course of my examination and treatment.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### **CONSENT TO X-RAY MINOR**

I am the parent or legal guardian of \_\_\_\_\_ who is a minor at \_\_\_\_\_ years of age. I authorize the performance of a diagnostic x-ray examination of this child [or ward] which Dr. Smith may consider necessary or advisable in the course of examination and/or treatment.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### **FEMALES: REGARDING POSSIBILITY OF PREGNANCY**

This is to certify that, to the best of my knowledge, I am not pregnant and that Dr. Smith has my permission to perform diagnostic x-ray examination. I have been advised that certain x-ray examinations, particularly those involving the pelvis, can be hazardous to an unborn child.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### **FEMALES: CONSENT TO X-RAY DURING PREGNANCY**

This is to certify that I am or may be pregnant and that Dr. Smith has my permission to perform diagnostic a x-ray examination involving my cervical spine [neck] or extremities [arms or legs] on the condition that lead shielding will be utilized over the trunk of my body. I have been advised that certain x-ray examinations, particularly those involving the pelvis, can be hazardous to an unborn child.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



Dr. Doug Smith  
**Chiropractor**

Spinal Health Care Center

1386 SE Lund Ave., Ste. #1, Port Orchard, WA 98366

Phone (360) 874-7494 Fax (360) 874-0586

**RECEIPT OF PRIVACY ACKNOWLEDGEMENT**

I have been presented with a copy Spinal Health Care’s “Notice of Privacy Policies” detailing how my information may be used and disclosed as permitted under Federal and State Laws. I understand the contents of the Notice, and request the following restrictions concerning the use of my personal medical information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If not signed by patient, please indicate relations to patient (e.g., parent)

**Relationship:** \_\_\_\_\_ **Witnessed by:** \_\_\_\_\_

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~ **INTERNAL USE ONLY** ~  
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If patient or patient’s representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below:

**Presented on [date & time]:** \_\_\_\_\_

**By [name & title]:** \_\_\_\_\_

**FEES & PAYMENT POLICIES**

**This form has been prepared for your convenience regarding our payment policies and fees. We offer several methods of payment for your Chiropractic care and you may choose the plan which best fit your needs. Please read carefully and choose the plan in which you prefer. This will enable us to better serve you and help to avoid misunderstandings in the future. Our main concern is for your health and we will do our best to help you.**

PLAN #1 – INSURANCE: If you have insurance which covers Chiropractic care, we will bill them directly. Until we have the completed, necessary information to verify Chiropractic coverage, you will be required to pay for your care. We prefer that you pay your deductible and/or co-payment at each appointment (vs. being billed by mail), but we can also set up a payment schedule that works for you. In the event the insurance check should come to you, you are expected to bring the check to us to be applied to your account. Remember, insurance companies will allow only a certain amount of visits per year for your corrective care, so you should have a plan to continue on your own when you reach maintenance level (except possibly, some accident injuries). At this point, refer to our family plan.

PLAN #2 – NON-INSURED: Fees are to be paid at the time of services are rendered, unless special arrangements have been made in advance. If there is a financial hardship, please speak with Dr. Smith.

PLAN #3 – MEDICARE: We will need a photocopy of your Medicare ID card for us to bill Medicare directly for you. Our office does accept assignment on Medicare claims, which means they will reimburse Dr. Smith directly.

PLAN #4 – FAMILY PLAN: Ask Dr. Smith for details.

PLAN #5 – WORK INJURY: for care related to an on-the-job injury, you must report the injury to your employer and obtain written consent from them prior to your second visit.

PLAN #6 – AUTO INJURY: You need to supply us with the accident report, your car insurance, health insurance, liable parties insurance and attorney, if applicable. Until necessary insurance information is gathered and verified, you will be required to pay for your care. We will bill your insurance directly. In the event the check should come to you, you are expected to bring the check to us to be applied to your account.

**I QUALIFY FOR AND UNDERSTAND THE REQUIREMENTS OF PLAN # \_\_\_\_\_.**

**Signature: \_\_\_\_\_ Date: \_\_\_\_\_**

**PRICE LIST OF FEES**

X-RAY	\$70.00-350.00	EXAM	\$50.00-160.00
CONSULTATION	\$100.00-180.00	ADJUSTMENT	\$40.00-65.00
TRACTION	\$35.00	ICE & HEAT	\$9.00-25.00
SUPPLIES	\$5.00-50.00	MASSAGE THERAPY	\$60.00-125.00
EXERCISE & STRENGTH PROGRAM	\$75.00-100.00		

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**ASSIGNMENT AND AUTHORIZATION TO PAY DOCTOR**

I, \_\_\_\_\_, hereby authorize, assign, and direct the

(Insurance Co. name) \_\_\_\_\_

To pay directly by check made out and mailed to:

**SPINAL HEALTH CARE CENTER, 1386 SE LUND, #1, PORT ORCHARD, WA 98366**

My expense benefits for any professional services from ongoing care rendered or at time of my settlement with the aforementioned insurance company otherwise payable to me directly. This payment shall not exceed my indebtedness to the above mentioned assignee.

This assignment of funds payable to me for services rendered by the above mentioned assignee takes priority over any and all future agreements I make with the aforementioned insurance carrier and specifically assigns, directs, and holds liable said insurance carrier to assure the above doctor/clinic is paid for total treatment charges on the receipt of billing of services rendered or at the time of settlement **by payment directly from the insurance carrier to the doctor/clinic**. Furthermore, this assignment and authorization takes priority and supersedes any document signed by me and the insurance carrier which excuses the insurance carrier from liability for payment of my health care cost at the above clinic.

Any document which permits the above insurance carrier to pay to me any sums for distribution of services rendered by the above mentioned doctor/clinic is hereby declared invalid, illegal and contrary to my wishes, and does not excuse liability on the part of the insurance carrier for direct payment of those total and/or ongoing costs of my care.

I fully understand that I am directly and fully responsible to said doctor/clinic for all chiropractic bills submitted by him/clinic for services rendered me, and that this agreement is made solely for the said doctor's/clinic's additional protection and in consideration of his/their awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee.

DATE: \_\_\_\_\_

SIGNATURE OF PATIENT OR PARENT/GUARDIAN (if minor)

DATE: \_\_\_\_\_

WITNESS: \_\_\_\_\_