GUTIERREZ FAMILY CHIROPRACTIC

AGREEMENT AND CONSENT FOR CARE

WHEN A PATIENT SEEKS CHIROPRACTIC HEALTH CARE, AND WE ACCEPT A PATIENT FOR SUCH CARE, IT IS ESSENTIAL FOR BOTH OF US TO BE WORKING TOWARDS THE SAME GOAL.
.

- WE DO NOT OFFER TO DIAGNOSE OR TREAT ANY DISEASE OR CONDITION OTHER THAN SPINAL SUBLUXATIONS. SPINAL SUBLUXATIONS ARE INTERFERENCE TO THE NORMAL FLOW OF MENTAL IMPULSES TRAVELING OVER AND THROUGH THE NERVE SYSTEM THUS INTERFERING WITH THE INNATE HEALING POTENTIAL OF THE BODY.

- HOWEVER, IF DURING THE COURSE OF A CHIROPRACTIC EXAMINATION WE ENCOUNTER A NON-CHIROPRACTIC OR UNUSUAL FINDING, WE WILL SO ADVISE YOU. IF YOU DESIRE ADVICE, DIAGNOSIS OR TREATMENT FOR THESE FINDINGS, WE WILL RECOMMEND THAT YOU SEEK THE SERVICES OF A HEALTH CARE PROVIDER WHO SPECIALIZES IN THOSE AREAS.

- THE METHOD OF CORRECTION WILL BE SPECIFIC CHIROPRACTIC SPINAL ADJUSTMENTS, THUS ALLOWING THE BODY TO WORK MORE EFFICIENTLY.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS. ALL QUESTIONS REGARDING THE DOCTORS OBJECTIVE PERTAINING TO MY CARE IN THIS OFFICE HAVE BEEN ANSWERED TO MY COMPLETE SATISFACTION.

PLEASE CONTINUE ON OTHER SIDE

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I ACCEPT CARE ON THIS BASIS_____

_____ SIGNATURE OF RESPONSIBLE DATE

PLEASE CONTINUE ON OTHER SIDE

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FINANCIAL POLICIES

Health and accident insurance are an agreement between the insurance carriers and you. GFC will not involve itself in any disputes between you and your insurance carrier.

Please **initial** your financial choice:

____ **INSURANCE** – I choose to have GFC bill my insurance company with the information I have provided them. I understand that any amount unpaid by my insurance company within 45 days of the date of service, that is not a write off, will be my responsibility. i.e.: co pays, percentages, and deductibles.

____ **PCD/PRE-PAID PLAN** – I choose to pay for my care at the time of service and receive the discounted rate of $35 an office visit. I understand that if I do not pay at the time of service my rate will go back to the usual and customary price of $45. I understand x-rays will be 20% off when paid at the time of service. I understand that Pre-Paid members receive scans for free.

____ **CASH** – I choose to pay GFC in full at the usual and customary rate of $45 for each visit at the time of service.

____ **MEDICARE** / MEDICARE PRICES – I choose to have GFC send Medicare any of my GFC financial and medical information. I choose to pay the discounted Medicare rate of $30. I understand that if I do not have Medicare coverage (yet I am 65 years or older) or if Medicare deems my visits medically unnecessary I will not be reimbursed.

____ **L&I or MVA** (PIP) – I choose to have GFC bill L&I or my auto insurance on my behalf. I understand that I will have no payments due unless the insurance companies deny my claim. At that time I will be responsible for any and all charges unpaid.

____ **3rd PARTY/PERSONAL INJURY** - I choose to have GFC hold all my bills until my claim is settled. I understand that a Lien will be filed so payment will be sent directly to GFC for the charges accrued. In the case that payment is sent to me, I understand that I will pay GFC in full at the time I receive my settlement.

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SIGNATURE _____ DATE _____

Financial Policies cont.

Please read and **initial** each section:

PAST DUE ACCOUNTS

____ If I get behind on my account balance more than 90 days, I will be sent to a third party collection agency.

1. Service Charge – A service charge of 1.5% per month on all balances of thirty days or greater, with a minimum $5.00 late charge, will be assessed in your account.
2. Venue – In case a legal action is commenced to collect this account, at the request of either party, venue for any legal action shall be placed in Snohomish County, WA.
3. Reasonable Attorney's Fees – If this account is not paid as agreed, and legal action is commenced to collect the amount due, I (we) agree that, in addition to other charges authorized herein, we will pay reasonable attorney's fees.

APPOINTMENTS

____ I understand when I make an appointment, this time has been reserved for me. I understand that in consideration of other patients and the GFC staff, a $20 fee **may** be charged for missed appointments. **This fee will be my responsibility, not my insurance's.** To avoid this fee, I will call ahead of time to let GFC know I won't be able to make it.

NSF

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____ I understand if I make a payment to GFC and the payment does not go through, I will be charged a $25 non-sufficient funds fee per RCW 62A.3-104.

1. Costs of collecting the amount of the check in the lesser of the check amount or forty dollars ($40), plus, in the event of legal action, court costs and attorney's fees, which will be set by the court.
2. Interest in the amount of the check which shall accrue at the rate of twelve percent per annum from the date of dishonor; and
3. Three hundred dollars ($300) or three times the face amount of the check; whichever is less, by award of the court.

SIGNATURE _____ DATE _____

GUTIERREZ FAMILY CHIROPRACTIC HEALTH HISTORY

NAME_____

MALE/FEMALE_____DATE_____

ADDRESS_____CITY_____STATE_____ZIP

_____

PHONE
#_____BIRTHDATE_____AGE_____SS#_____
___

WORK#_____ EMPLOYER NAME_____

CELL#_____

SPOUSE'S NAME _____ SPOUSE'S WORK
PHONE_____

WHO MAY WE CONTACT IN CASE OF AN EMERGENCY (SOMEONE NOT LIVING WITH YOU)

NAME_____ PHONE
NUMBER_____

WHO MAY WE THANK FOR REFERRING YOU
HERE?_____

PLEASE INDICATE POSSIBLE INSURANCE
COVERAGE_____

WHAT TYPE OF SERVICE DO YOU DESIRE? CHECK ONE.

- ❑ TEMPORARY SYMPTOMATIC CHANGES (A REDUCTION OF SYMPTOMS 50-100% WITH THE LIKELIHOOD OF RE-OCCURRENCE).
- ❑ SPECIFIC CORRECTION & STABILIZATION (YOUR HIGHEST HEALTH POTENTIAL, CORRECTIVE CARE, WITH LOW LIKELIHOOD OF RE-OCCURRENCE)

WHAT COMPLAINT BRINGS YOU TO G.F.C.?

_____

HOW LONG HAVE YOU HAD THIS PROBLEM?

_____

WAS IT THE RESULT OF: (AUTO ACCIDENT) (JOB INJURY) (SLOW ONSET) (OTHER)

WHAT HAVE YOU TRIED FOR THIS PROBLEM?

DESCRIBE_____

WHY DO YOU BELIEVE YOUR BODY HAS NOT BEEN ABLE TO HEAL FROM

THIS?_____

_____

_____

HAVE YOU BEEN UNABLE TO WORK?

FROM_____TO_____

WHAT DOES THIS PROBLEM INTERFERE

WITH?_____

HAVE YOU EVER BEEN TO A CHIROPRACTOR BEFORE? IF YES, DR.'S

NAME_____

APPROXIMATE DATE OF LAST

ADJUSTMENT_____

WHO IS YOUR FAMILY

PHYSICIAN?_____PHONE_____

DATE AND LOCATION OF RECENT SPINAL X-

RAYS_____

PLEASE COMPLETE OTHER SIDE

DESCRIBE PHYSICAL ACTIVITIES INVOLVED WITH YOUR WORK OR

LIFESTYLE_____

_____

_____

PLEASE GIVE APPROXIMATE DATE AND DESCRIPTION FOR ALL PAST:

AUTO

ACCIDENTS_____

____

_____

_____

ALL OTHER FALLS AND INJURIES

_____

_____

_____

_____

ANY CURRENT OR PAST HEALTH

PROBLEMS_____

_____

_____

HOSPITALIZATIONS_____

_____

MEDICATIONS (INCLUDING BIRTH

CONTROL)_____

_____

_____

IN THE LAST 24 HOURS HAVE YOU DONE ANY OF THE FOLLOWING?

(PLEASE CHECK ALL THAT APPLY)

__HAD A MASSAGE __BEEN IN THE SUN __WORKED OUTSIDE

__HAD A WORKOUT __HAD PHYSICAL THERAPY __BEEN IN THE TANNING BED

__TAKEN ANY DRUGS (RX OR RECREATIONAL) __USED ARTIFICIAL SWEETENERS

FEMALE HISTORY? ARE YOU PREGNANT? IF YES, DUE

DATE_____

I HEREBY WITNESS THAT TO THE BEST OF MY KNOWLEDGE THE ABOVE ACCURATELY REPRESENTS MY COMPLETE HEALTH HISTORY.

SIGNED_____DATE_____

_____

*GUARDIAN/FINANCIALLY RESPONSIBLE PERSON IF UNDER

18_____

Gutierrez Family Chiropractic

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPPA)

You may refuse to sign this acknowledgement

I, _____ have received a copy of this office's Notice of Privacy Practices (HIPPA).

_____
Date_____
(Signature)

_____
Date_____
(Guardian)

for office use only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

____ Individual refused to sign
____ Communication barriers prohibited obtaining the acknowledgment
____ An Emergency situation prevented us from obtaining acknowledgment
____ Other (please Specify)

Gutierrez Family Chiropractic Patient Intake Form

Name_____Date_____

Please mark each item that represents reoccurring or present health status.

- ❑ LOSS OF MEMORY
- ❑ LIGHTHEADEDNESS
- ❑ FAINTING
- ❑ EAR NOISES
- ❑ SESITIVITY TO LIGHT
- ❑ BLURRED VISION
- ❑ SHORTNESS OF BREATH
- ❑ IRREGULAR HEARTBEAT

- ❑ NECK STIFFNESS
- ❑ GRINDING SOUNDS IN NECK

- ❑ LIMITED SHOULDER MOVEMENT
- ❑ DIFFICULTY RAISING ARMS ABOVE HEAD
- ❑ SHOULDER SPASMS
- ❑ NUMBNESS
- ❑ ARMS
- ❑ HANDS
- ❑ FINGERS
- ❑ CARPEL TUNNEL

- ❑ DIFFICULTY RISING FROM SEATED POSITION
- ❑ LOWER BACK SPASMS
- ❑ DIFFICULTY STANDING FOR LONG PERIOD OF TIME

FUNCTIONAL PROBLEMS

- ❑ UPSET STOMACH
- ❑ UPSET BOWELS
- ❑ NAUSEA
- ❑ HEARTBURN
- ❑ GAS PAINS
- ❑ EXCESSIVE GAS
- ❑ FREQUENT URINATION
- ❑ BEDWETTING
- ❑ FATIGUE
- ❑ SLEEP DISTURBANCES
- ❑ NOT MENTALLY ALERT
- ❑ CRANKY
- ❑ NERVOUS
- ❑ EASILY STRESSED

- ❑ FREQUENT COLDS/FLU'S
- ❑ SORE THROATS
- ❑ ALLERGIES
- ❑ ASTHMA
- ❑ POOR APPETITE
- ❑ PERSISTANT COUGH

- ❑ MUSCLE CRAMPING
- ❑ EXCESSIVE MENSTRUAL CRAMPING
- ❑ MESTRUAL IRREGULARITY
- ❑ DIFFICULTY GETTING PREGNANT
- ❑ HOT FLASHES

PAIN COMPLAINTS

- ❑ HEADACHES
- ❑ MIGRAINS
- ❑ NECK
- ❑ BETWEEN SHOULDERS
- ❑ ELBOW
- ❑ RIBS
- ❑ LOW BACK
- ❑ GROIN
- ❑ HIP
- ❑ TAILBONE

DIFFICULTY WITH:

- ❑ SITTING
- ❑ LYING DOWN
- ❑ WORKING
- ❑ HOUSEWORK
- ❑ BENDING

OTHER_____
_____
_____