Advanced Back and Neck Pain Clinic
4621 35th Avenue SW Suite B Seattle WA 98126
Dr. Keshika Nanda DC & Dr. Christopher Prouty DC

Name: _____ DOB (mm/dd/yyyy)_____Todays Date_____

Phone: _____(work/cell/home- please circle) Age: ____

Address: _____City_____State_____Zip_____

Email: _____ Do you have insurance? _____ (please give card to front desk)

Employer: _____Occupation_____ SSN_____

Reason for todays visit/current symptoms_____

Date of injury/onset of symptoms_____

How did symptoms start?_____

Has this happened before? Y/N Has this been treated before? Y/N

Any diagnostic testing? Y/N. please explain_____

What has worked to help alleviate symptoms (medication/therapy etc)_____

List any medication/herbs/vitamins you are taking_____

Spinal surgeries Y/N , if yes when (list all)_____

Do you suffer from Headaches? Y/N How long do they last? ____How many times per week/month?___

Conditions you have been diagnosed as having?

Anxiety Diabetes Depression Bleeding Disorder Arthritis Stroke

Asthma Gout High Blood Pressure Memory Loss Heart Attack

Kidney Stone Ringing in ears Anemia Thyroid Disease

Other: _____

Fractures? (describe)_____

Goals for treatment: _____

Is there anything else we can help you with? _____

Who can we thank for referring you? _____

Have you been treated by a Chiropractor before? Y/N If yes, When? _____

Type of Chiropractic treatment in the past? Manual or Instrument Adjustments or Both

Emergency Contact:

Name: _____Relationship_____Phone Number_____

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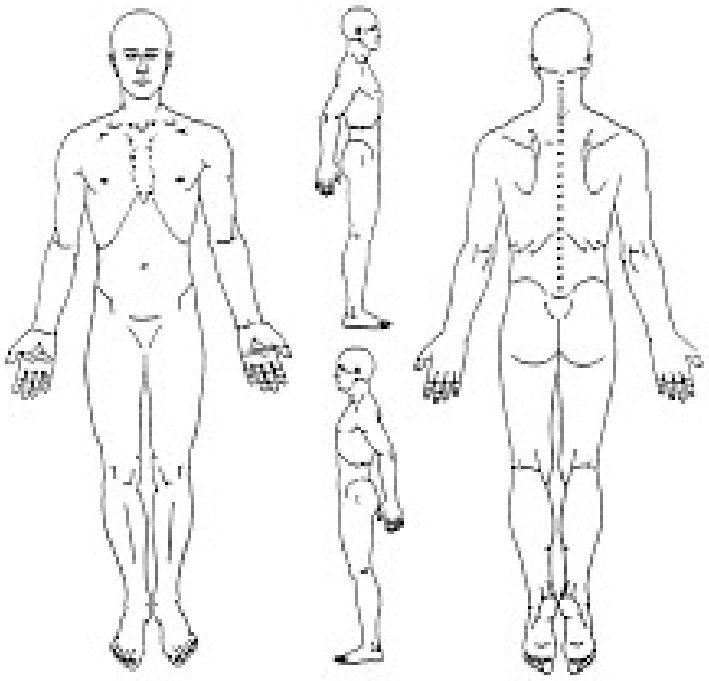
Please Indicate Areas of Pain (P), Numbness (N), Weakness (W), Stiffness/Soreness(S)



Chief Complaint_____Secondary Complaint_____
Other Complaints_____

Pain Level

Please indicate your USUAL (average)level of pain and the WORST pain since onset.
"0" is no pain at all, "10" is the worst pain possible.

Usual (Average): _____/10 Worst pain: _____/10

Daily Tasks

List 3 daily tasks that give you the most problems due to symptoms (list pain level 0-10)

1. _____ Pain_____/10
2. _____ Pain_____/10
3. _____ Pain _____/10

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Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. 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. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and the function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social wellbeing, not merely the absence of disease or infirmary.

One disturbance to the nervous system is called vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment**. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be inclined.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.
All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks, and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____ _____

Print name Signature Date

Consent to evaluate and adjust a minor child: I,_____ being the parent or legal guardian of _____ have read and fully understand the above informed consent and hereby grant permission for my child to receive chiropractic care.

Notice of Privacy

We keep a record of the health care services provided. You may ask to see and receive a copy of that record. You may also seek to have to record corrected. This information will not be disclosed to others unless under your direction or as required by law.

The Privacy Notice (available for review at the Front Desk) explains this information in great detail. My signature below signifies that I have read and understand the Privacy Notice provided.

_____ _____ _____

Print name Signature Date

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Office Policies and Procedures

For your convenience, we can bill your insurance company.

In order to do this, we will need your current insurance information. (If you have secondary insurance, we will need that information as well.) Once we have that information, we can determine what the cost of each visit will be do you. Patients submit payment at the time of service. Your deductible, co-pay and co-insurance are pain at the front desk.

Your insurance policy is an agreement between you and the insurance company. Our relationship is with YOU, not with your insurance company. Thus, all charges are ultimately your responsibility. If you have selected one of our chiropractors at Advanced Back and Neck Pain Clinic, because they are preferred providers on your plan, be aware that we have signed extensive contracts as a service to you in efforts to get you reimbursed for what you pay into insurance. Regardless of our association with your insurance, whatever amount they do no pay towards our services, you are contractually obligated to pay for. We are NOT allowed to waive co-insurance or co-pays.

We reserve the right to chart $45.00 for a missed appointment fee if not given 24 hours notice.

Co-Pay: The set amount your insurance company puts on each visit as your responsibility.
Co-Insurance: A percentage cost of each visit your insurance company puts as your responsibility.

I hereby Authorize my insurance benefits be paid directly to the healthcare provider as well as release of any information by the provider or insurance company required for this claim. I am financially responsible for any balance due. I agree to make payment arrangement; pay $5 or 1% interest per month (whichever is great) on unpaid balances over 90 days and all reasonable expenses such as attorney cost, court cost should your account be referred for collections.

Patient(parent/guardian)Signature_____Date_____
Patient Name (Please print) _____

Note About Financial Hardship

On a case by case basis you may qualify for "financial hardship." Each insurance company has a different agreement with you, the patient and us the providers. It is important that we comply with our contracts. Please note, many insurance companies do no allow under ANY circumstance that we do not collect copay or coinsurance.
To qualify for reduced payments and/or extended monthly payments plans, you insurance company must first allow for financial hardship. Your household income must be below 200% of the national poverty level and/or your monthly discretionary income must be below $500. We do not ever want to turn away anyone in need of care due to finances. However, under contract, we must adhere by the strict insurance company rules. If you would like to apply for financial hardship, please ask. We will treat your situation with respect and privacy and provide the necessary forms.
As a courtesy to our patients, we also offer cash plans, time-of-service discounts, which are reasonably priced and may assist in making care accessible and affordable. In these cases, we do not bill insurance companies, and patient pay out of pocket for the services. Please ask us for further information.