Fitzpatrick Chiropractic Clinic

Health History

Today's Date_____

Name_____ Soc. Sec. No._____ Home phone # _____
Cell PH #_____ Work # _____ Email Address_____
Address_____ City _____ Zip Code_____
Age _____ Birth Date _____ Marital: M S W D How many children _____
Occupation_____ Employer_____
Spouse's name _____ Spouse's Phone # _____
Patients nearest relative not living with you _____ Phone # _____
Address _____ City_____ Zip Code _____
Who referred you to our office? _____
What do you believe is wrong with you?_____
Is your current condition the result of an accident? □ Yes □ No
If yes □ Work related? □ Auto Accident? □ Other? _____
Date of Injury _____ What days have you lost from work? _____
Have you seen other doctors for this condition? □ Yes □ No If yes, please list: _____
If yes, did your condition: □ Totally improve □ Partially improve □Worsened □ Remained the same
What operations have you had? _____
Describe: _____
Are you pregnant? □ Yes □ No Date of onset of last menstrual cycle? _____

Patient Completes This Section:

(Please fill in selections completely)

Symptoms began on: | | | |

1. Briefly describe your symptoms:

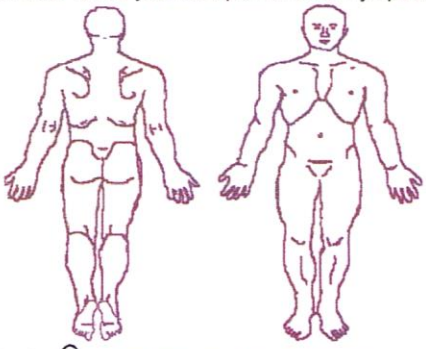
2. How did your symptoms start?

3. Average pain intensity:

Last 24 hours: **no pain** (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) **worst pain**

Past week: **no pain** (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) **worst pain**

Indicate where you have pain or other symptoms:



4. How often do you experience your symptoms?

(1) Constantly (76%-100% of the time) (2) Frequently (51%-75% of the time) (3) Occasionally (26% - 50% of the time) (4) Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)

(1) Not at all (2) A little bit (3) Moderately (4) Quite a bit (5) Extremely

6. How is your condition changing, since care began at *this* facility?

(0) **N/A — This is the initial visit** (1) Much worse (2) Worse (3) A little worse (4) No change (5) A little better (6) Better (7) Much better

7. In general, would you say your overall health right now is...

(1) Excellent (2) Very good (3) Good (4) Fair (5) Poor

Patient Signature: X _____ **Date:** _____

Any additional symptoms: _____

Please check the appropriate box on any of the symptoms you are now experiencing or have had previously

Fitzpatrick Chiropractic Clinic
465 Rainier Blvd. North
Issaquah, WA. 98027

KEY

O- Occasional
F- Frequent
C-Constant

THIS IS A CONFIDENTIAL HEALTH REPORT

O F C GENERAL

☐☐☐ Allergy
☐☐☐ Convulsions
☐☐☐ Dizziness
☐☐☐ Fainting
☐☐☐ Headache
☐☐☐ Neuralgia
☐☐☐ Numbness

MUSCLE & JOINT

☐☐☐ Arthritis
☐☐☐ Back pain (lower)
☐☐☐ Back pain (upper)
☐☐☐ Bursitis
☐☐☐ Neck pain/stiffness
☐☐☐ Pain between shoulders
☐☐☐ Shoulder pain/numbness
☐☐☐ Arm pain/ numbness
☐☐☐ Elbow pain/numbness
☐☐☐ Hand, wrist pain/numbness
☐☐☐ Hip pain/numbness
☐☐☐ Leg pain/numbness
☐☐☐ Knee pain/numbness
☐☐☐ Foot, ankle pain/numbness
☐☐☐ Sciatica
☐☐☐ Swollen joints

O F C GASTRO-INTESTINAL

☐☐☐ Colon trouble
☐☐☐ Constipation
☐☐☐ Diarrhea
☐☐☐ Difficult Digestion
☐☐☐ Distension of Abdomen
☐☐☐ Gallbladder trouble
☐☐☐ Hemorrhoids
☐☐☐ Liver trouble
☐☐☐ Stomach Pain

EYES/EARS/NOSE/THROAT

☐☐☐ Asthma
☐☐☐ Colds
☐☐☐ Deafness
☐☐☐ Earache
☐☐☐ Ear discharge
☐☐☐ Ear noise
☐☐☐ Eye pain
☐☐☐ Nasal obstruction
☐☐☐ Nosebleeds
☐☐☐ Sinus infection

CARDIO-VASCULAR

☐☐☐ Hardening of arteries
☐☐☐ High blood pressure
☐☐☐ Low blood pressure
☐☐☐ Pain over heart
☐☐☐ Poor circulation
☐☐☐ Rapid heart beat
☐☐☐ Slow heart beat
☐☐☐ Swelling of ankles

O F C RESPIRATORY

☐☐☐ Chest Pain
☐☐☐ Chronic Cough
☐☐☐ Difficult breathing
☐☐☐ Spitting up blood
☐☐☐ Spitting up phlegm
☐☐☐ Wheezing

SKIN

☐☐☐ Bruise easily
☐☐☐ Dryness
☐☐☐ Eruptions/rash
☐☐☐ Varicose Veins

GENTO-URINARY

☐☐☐ Bed-wetting
☐☐☐ Bladder problems
☐☐☐ Blood in urine
☐☐☐ Frequent urination
☐☐☐ Kidney problems
☐☐☐ Painful urination
☐☐☐ Prostate problems
☐☐☐ Pus in urine

FOR WOMEN ONLY

☐☐☐ Breast problems
☐☐☐ Cramps or back pain
☐☐☐ Menstrual problems
☐☐☐ Hot flashes
☐☐☐ Irregular cycles
☐☐☐ PMS syndrome
☐☐☐ Menopausal symptoms
☐☐☐ Vaginal problems

Drugs/medications you are presently taking:

☐ Nerve pills ☐ Pain killers
☐ Muscle relaxers ☐ "PEP" pills
☐ Tranquilizers ☐ Insulin

Date of last: Physical Exam _____
Spinal Exam _____
Spinal X-ray _____

☐ Diuretics ☐ Birth control pills

☐ Other _____

Chest X-ray _____

Blood Test _____

Urine Test _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

Signature_____ Date_____

Fitzpatrick Chiropractic Clinic Billing Policies

465 Rainier Blvd. North
Issaquah, WA 98027
(425) 392-5321

We have the experience and knowledge to process your insurance claims properly. However, we will only re-submit a bill to your insurance company for the same service twice. If we still do not receive payment it is then your immediate responsibility to appeal your denied charges. If your appeal is denied we can discuss an appropriate payment plan with you for any non-covered portions. **You should be aware that verifying eligibility is never a guarantee of payment.** *Payment is determined only after the insurance carrier receives and reviews your claim, and that health and accident insurance policies are an arrangement between the insurance carrier and yourself, thus, it is understood that all services rendered to you are charged directly to you and that you are responsible for full payment.*

( ) MANAGED CARE NETWORKS- If your insurance carrier works through a managed care network, a referral from your medical doctor/PCP may be required. Acquiring and making sure the referral is valid and current is your responsibility; services denied because they were not authorized by your PCP are your responsibility.

( ) NO INSURANCE- **Payment at the time of services is required.** If payment each visit creates a hardship for you, we will extend a limited credit, with payment frequency set on an individual basis. Accumulated charged should not exceed $100 at any given time.

( ) PARTIAL COVERAGE HEATLH INSURANCE- Your co-pay and portions not covered by insurance are **due at the time of services rendered.**

( ) PERSONAL INJURY CASE- When a patient has been involved in a motor vehicle accident and another party has been found to be at fault, both your own auto insurance as well as the at –fault party's insurance information is required. Both companies will be billed; your own insurance will pay the billings initially through the PIP portion of your policy. Using PIP will not raise your rates. The at-fault party's carrier will reimburse your insurance carrier for the medical paid out at the time of the settlement. After initiating care as a PI, the billing of care relative to the PI will be converted to another type of billing unless you have either been released from the PI by the Doctor, or your PIP coverage has been exhausted.

( ) NO PIP INSURANCE- When you are depending on the at-fault party for payment of your care, as a courtesy, we will extend credit until maximum medical improvement, or care is denied. **This credit is extended with the express understanding that your bill for all services rendered and charges on account will be paid in full at the time of settlement.**

I have read, understood and agree with the terms of this contract as set forth above.

_____	_____	_____
Signature of Patient	Printed Name	Date

ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES

JAMES E. FITZPATRICK, D.C., P.S.
465 RAINIER BLVD. NORTH, SUITE A
ISSAQUAH, WA. 98027
(425) 392-5321

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

- ☐ Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- ☐ Obtain payment from third-party payers for my health care services.
- ☐ Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my Chiropractor's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices.* I understand that my Chiropractor has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patients Name: _____ Date: _____
Signature: _____
Relationship to Patient: _____
Dependent family members also covered by this acknowledgement:
_____

- -

For Office Use Only!

We were unable to obtain the patient's written acknowledgement of our *Notice of Privacy Practices* due to the following reason:

- ☐ The Patient refused to sign
- ☐ Communication barriers
- ☐ Emergency situation
- ☐ Other _____

Missed Appointment
"No Show" Fee's

If you need to cancel or reschedule an appointment, call us at least two hours ahead please.

If you fail to arrive for your appointment and have not notified us two hours in advance, you will be charged a No Show fee of $50.00

The no show fee is $50.00, it will be billed to the patient, this fee is not covered by Insurance and is due prior to your next appointment.

By signing below, you acknowledge that you have received this notice and understand this policy.

Patient name (please print): _____
Date:_____
Signature: _____