TIMMS Family Chiropractic

1412 NE 134th St, Ste 100
Vancouver, WA 98685
Phone. 360-693-7781
Fax. 360-693-1688

1404 NE 134th St Ste 170
Vancouver, WA 98685
Phone. 360-574-6594
Fax. 360-574-2235

NEW PATIENT REGISTRATION

Patient Name: ____ Today's Date: ______________

Date of Birth: ______________ Age: _____ Sex: M / F / Other Social Security #: _______ - _____ - ________

Address: ____
number street city state zip

Cell Phone: (_____) ______ - _________ Alt. Phone: (_____) ______ - _________

E-mail: ____

Employer: _____________________________ Occupation: _____________________________

Primary Physician's Name: ___________________________________ Phone: (_____) ______ - _________

Have you seen a chiropractor before? ☐ No ☐ Yes If **yes**, when: ______________________________

Emergency Contact: _______________________________________ Phone: (_____) ______ - _________

Who may we thank for referring you? ____

PAYMENT INFORMATION

☐ SELF-PAY: I will pay my balance in full at time of service
☐ BILL INSURANCE: I intend to bill my regular insurance plan
☐ Auto collision Insurance
☐ Worker's Comp Insurance

- -

Policyholder: ☐ Self ☐ Other Relationship to Patient: ______________________

Policyholder Name: ______________________________ Policyholder Phone #: (_____) ______ - ________

Policyholder Address: ____________________________ Policyholder Date of Birth: ____________________

Insurance Co Name: ______________________________ Date of collision/work injury: __________________

ID# (or claim #): ________________________________ Group #: ________________________________

Rep Name: _____________________________________ Customer Service #: (_____) ______ - ________

PAYMENT POLICY

By signing below, I understand that full payment for all services and products I receive from Timms Family Chiropractic PLLC is required at the time of service, except that portion billed to my insurance company. I understand that Timms Family Chiropractic PLLC may bill my insurance carrier directly, if I so request, and that I am responsible for any services not covered by my insurance company, as well as, any co-pay, coinsurance, or deductible required by my insurance. I instruct my insurance carrier to pay this office directly for all services and authorize the release of any information necessary to secure payment.

By signing this form I affirm that I have given true and complete information.

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Signature (Patient or Guardian) Date

FINANCIAL POLICY, HIPAA & CONSENT FORM

Clinic Financial Policy

Insurance Plans Billed: ASH- Aetna, BCBS, Cigna, Health-Net, Providence; Pacific Source; United Healthcare; Regence; Kaiser
Time of Service Fees: We offer a discount for same day payment for services rendered.
Missed Appointments or Late Cancellations: 24 hours' notice is required; $40.00 cancellation fee applies.
Personal Injury Claims & Billing

- Auto accident and worker's comp related injuries require verification of an existing claim prior to examination and treatment.
- If examination and treatment for auto and work-related injuries is not covered by any or all personal injury insurance companies involved, I, the patient, am responsible for all fees for treatment.

_________ I, the patient, am responsible for paying all out-of-pocket costs which may include time-of-service fees, co-pays, or co-insurance. For insurance companies that Timms Family Chiropractic PLLC is not contracted with, a Super Bill/Invoice can be provided upon request which can be submitted to insurance plans for potential reimbursement.

HIPAA Notice of Privacy Practices

Your protected health information may be used and disclosed by your physician, our staff, and others outside of this office that are involved in your care for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law. All your information is strictly confidential.

_________ I, the patient, consent to the use and disclosure of my Protected Health Information by Timms Family Chiropractic PLLC.

Examination & Treatment Consent

Chiropractic examination and therapeutic procedures (including spinal adjustment, ultrasound/laser, heat/ice application, electrotherapy, and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have side-effects. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. Side effects include, but are not limited to soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare and their association with spinal adjustments (manipulation) is debated. These complications include injury to the arteries in the neck which may be associated with stroke and serious neurologic impairment, injuries to the spinal discs, and spinal fractures. Serious complications such as stroke are estimated to be between 0.5-2 incidents per million for adjustments of the neck and low back.

_________ I, the patient, have read and understand the above statements regarding treatment side-effects. I was made aware of procedures, alternative treatments, risks, and I was provided the opportunity to ask questions regarding recommended treatment(s) &/or procedure(s). I also understand that there is no guarantee or warranty for a specific cure or result.

Please read the following carefully and initial:

- _________ I understand that if I have any prosthetics or surgical implants (including breast implants, an artificial joint, pacemaker, etc.), I should discuss this with the physician because it may affect care.
- _________ Notice to pregnant women: all females must alert their doctor if suspecting or having confirmed pregnancy as some therapies prescribed could present a risk to the pregnancy.
- _________ I understand that I play an important role in my own health care. Just as a patient can choose to discontinue care at any time, Timms Family Chiropractic PLLC reserves the right to terminate a doctor-patient relationship if a patient is continually unable to comply with payment and/or reasonable treatment plans.

By signing this application, I affirm that I have given true and complete information.

_________________________ _________________________ _____________
Print Name Patient Signature (or Guardian) Date

_________________________ _____________
Physician Signature Date

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NEW PATIENT INTAKE

Patient Name: ____ DOB: ________________ Date: ________________

Describe symptoms (include referral pain and the cause of injury/pain): Date of onset: Location of symptoms:

1. ____ ___________

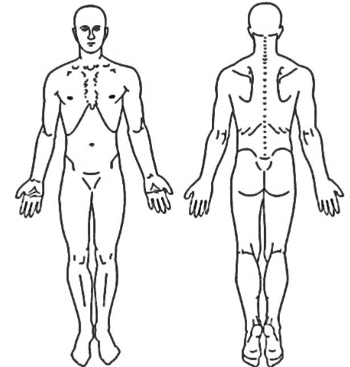
____

2. ____ ___________

____

3. ____ ___________

____



Fill in blanks if needed *Pain*: (0)=No Pain (10)=Worst Pain *Status*: B=Better S=Same W=Worse F=Flare-Up

Symptom	*Side*	*Pain*	*Pain Freq./Day*	*Status*	*Pain Quality*	*Pain Increased or Caused by*
☐ *Headache*	L R	( )	________ %	B S W F	Sharp Dull Ache Stab Throb ________	Sit Stand Walk Bend ________
☐ *Neck Pain*	L R	( )	________ %	B S W F	Sharp Dull Ache Stab Throb ________	Sit Stand Walk Bend ________
☐ *Upper Back*	L R	( )	________ %	B S W F	Sharp Dull Ache Stab Throb ________	Sit Stand Walk Bend ________
☐ *Low Back*	L R	( )	________ %	B S W F	Sharp Dull Ache Stab Throb ________	Sit Stand Walk Bend ________
☐ *Shoulder*	L R	( )	________ %	B S W F	Sharp Dull Ache Stab Throb ________	Sit Stand Walk Bend ________
☐ *Hip*	L R	( )	________ %	B S W F	Sharp Dull Ache Stab Throb ________	Sit Stand Walk Bend ________
☐ ________	L R	( )	________ %	B S W F	Sharp Dull Ache Stab Throb ________	Sit Stand Walk Bend ________
☐ ________	L R	( )	________ %	B S W F	Sharp Dull Ache Stab Throb ________	Sit Stand Walk Bend ________
☐ ________	L R	( )	________ %	B S W F	Sharp Dull Ache Stab Throb ________	Sit Stand Walk Bend ________
☐ ________	L R	( )	________ %	B S W F	Sharp Dull Ache Stab Throb ________	Sit Stand Walk Bend ________

Activity Affected (work, exercise, sit, stand, drive, etc.) *Functional Ability*: (0)=Not able to perform (10)=Best ability to perform

1. ____ ( ) or ________ %
2. ____ ( ) or ________ %
3. ____ ( ) or ________ %

Current medications and reasons for taking them: ____

____

Have you ever experienced:	No	Yes	If yes, briefly explain:
- broken bone	☐	☐	____
- hospitalization/surgery	☐	☐	____
- strains/sprains	☐	☐	____
- fallen/struck unconscious	☐	☐	____
- auto collision/work injury	☐	☐	____

List any other health conditions: ____

____

EXERCISE	WORK ACTIVITY	OTHER		
☐ None	☐ Sitting	☐ Smoking ->	Packs/day	________________
☐ Moderate	☐ Standing	☐ Alcohol ->	Drinks/week	________________
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine ->	Cups/day	________________

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☐ Heavy ☐ Heavy Labor ☐ Stress level -> Reason ____________________

REVIEW OF SYSTEMS

Patient Name: ____ DOB: ______________ Date: ______________

All information will be kept strictly confidential. Your responses will help determine if chiropractic treatment will benefit you. Unless we sincerely feel that your condition will respond satisfactorily, we will not recommend treatment. Please indicate all CURRENT or PAST conditions. To be responsible for your case, we need your complete health history.

C = Current problem P = Past problem

C P Muscle / Joint
- ☐ ☐ Neck pain, stiffness
- ☐ ☐ Pain b/t shoulders
- ☐ ☐ Low back pain
- ☐ ☐ Sciatica
- ☐ ☐ Painful tailbone
- ☐ ☐ Poor posture
- ☐ ☐ Spinal curvature
- ☐ ☐ Foot trouble
- ☐ ☐ Swollen joints
- ☐ ☐ Bursitis

C P Pain
- ☐ ☐ Headache
- ☐ ☐ Eye
- ☐ ☐ Ear
- ☐ ☐ Abdomen
- ☐ ☐ Chest
- ☐ ☐ Shoulders
- ☐ ☐ Upper Arm
- ☐ ☐ Elbows
- ☐ ☐ Forearm
- ☐ ☐ Hand
- ☐ ☐ Hips
- ☐ ☐ Thigh
- ☐ ☐ Knee
- ☐ ☐ Shin
- ☐ ☐ Ankle
- ☐ ☐ Feet

C P Numbness
- ☐ ☐ Shoulders
- ☐ ☐ Upper Arm
- ☐ ☐ Forearm
- ☐ ☐ Thigh
- ☐ ☐ Shin / calf
- ☐ ☐ Feet
- ☐ ☐ Hands

C P General
- ☐ ☐ Dizziness
- ☐ ☐ Fainting
- ☐ ☐ Concussion
- ☐ ☐ Allergy
- ☐ ☐ Skin rash
- ☐ ☐ Enlarged glands

C P Cardiovascular
- ☐ ☐ Hardened arteries
- ☐ ☐ High blood pressure
- ☐ ☐ Low blood pressure
- ☐ ☐ Pain over heart
- ☐ ☐ Poor circulation
- ☐ ☐ Rapid heartbeat
- ☐ ☐ Slow heartbeat
- ☐ ☐ Swelling of ankles

C P Gastrointestinal
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Jaundice
- ☐ ☐ Liver trouble
- ☐ ☐ Nausea
- ☐ ☐ Vomiting

C P Genitourinary
- ☐ ☐ Blood in urine
- ☐ ☐ Frequent urination
- ☐ ☐ Lose bladder control
- ☐ ☐ Kidney infection
- ☐ ☐ Painful urination
- ☐ ☐ Prostate trouble

C P Women Only:
- ☐ ☐ Congested breasts
- ☐ ☐ Lumps in breast
- ☐ ☐ Menstrual pain
- ☐ ☐ Irregular cycle
- ☐ ☐ Excessive flow
- ☐ ☐ Hot flashes
- ☐ ☐ Menopause

C P Respiratory
- ☐ ☐ Chronic cough
- ☐ ☐ Difficult breathing
- ☐ ☐ Spit up blood

Check any conditions you have presently OR have had in the past:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Edema
- ☐ Emphysema
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ Herpes
- ☐ Multiple sclerosis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal disease

Pacemaker (or other medical implant): ☐ No ☐ Yes **Pregnant (females)**: ☐ No ☐ Yes ☐ Planning

List any family history of serious illness (i.e. heart disease, stroke, cancer, diabetes):

____

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