Chiropractic Registration

Patient Demographics:

Last Name: ____________________ First Name: ______________________ MI: _____

DOB: ______/_______/_______ Gender: _________ SSN: ______ - ______ - ______

Marital Status: (circle one) Single Married Other

Home Address Line 1: ____________________________________ Address Line 2:___________

City: _____________________________ State: ______ Zip: __________

Home #: ______/ _______/ _______ Work #: ______/ ______/ _______

Cell #: ______/ _______/ ________ Preferred Phone: ________________ (cell,home,work)

Email: ________________________________

How did you hear about us? Website Newspaper Friend Other ______________________

Employment Status: (circle one) Employed Full -Time Student Part Time Student Retired

Professional Title: ____

Employer Name: ______________________________ Employer Phone: _____/ ________/__________

Address Line 1: _________________________________

Employer City: ___________________________ State: ______ Zip: ___________

Emergency Contact:

Contact Name: ______________________________ Relationship to Patient: ___________________

Address Line 1: _________________________________

City: ____________________________ State: ______ Zip: ___________

Home #: ______/ _______/ ________ Work #: ______/ ______/ _______

Cell #: ______/ _______/ ________

Signature: ____________________________________ **Date**: __________________________

Deborah Kloby, D.C., PLLC,
32123 1st Ave S Ste A4, Federal Way, WA 98003
Office: 253-874-5008 Cell: 253-376-1009 Fax: 253-874-5024

Present Complaints

Please circle the appropriate complaints

Headache
Mental dullness
Loss of memory
Dizzy
Neck pain
Fainting
Upper back pain
Lower back pain
Neck restriction
Nervousness

Feet/hands cold
Depression
Rib Pain
Neck Stiffness
Shortness of breath
Upper back stiffness
Lower back stiffness
Eye strain or pain
Fear
Head seems heavy

Confusion
Constipation
Unbalanced
Chest pain
Ears ringing/buzzing
Mid-back pain
Blurred vision
Loss of taste
Irritability

Pins & Needles in arms
Right or Left
Pins & Needles in arms
Right or left
Pins & Needles in
Right or left
Mid-Back stiffness
Double Vision
Loss of smell
Tension

Circle All that Apply:

Difficulty in	Standing	Sitting	Bending	Walking	
Pain radiation to the	Right Arm	Left Arm	Right Leg	Left Leg	
Pain radiating to	Neck	Ribs	Shoulders	Arms	Base of Skull
Cannot lift	Light	Moderate	Heavy	Repetitive	
Other					

Since the time this/these complaint(s) began, what, if anything, have you tried that DID NOT work?

Has the problem interrupted your sleep? Yes/no How? ___________________________

Does anyone in your family have the same or similar complaint(s):

1. _______________________________________Specialty __________________________
2. _______________________________________Specialty __________________________
3. _______________________________________Specialty __________________________

Relevant medical history: Please **circle the conditions** you now have or you have had previously.

Arthritis
Asthma
Anemia
Pack pain or spasm
Cancer (type)
Concussion
Convulsion
Diabetes
Digestion problems
Dizziness

Epilepsy
Fibromyalgia
Hand or wrist pain
Headaches
Heart problems
Hepatitis (A, B, or C)
High blood pressure
HIV
Measles
Multiple Sclerosis

Muscular Dystrophy
Neck pain or spasms
Neuritis
Numbness polio
Rheumatic fever
Sinus trouble
Sciatica
TB
Venereal disease

Present Complaints

List any surgery that you have had and approximate dates:

1. ___________________________Date: _____________ Dr.: ____________________________
2. ___________________________Date: _____________ Dr.: ____________________________
3. ___________________________Date: ____________ Dr.: ______________________________
4. ___________________________Date: ____________ Dr.: ______________________________

Are you allergic to any medications? Yes/No
If yes, please list: ____
Are you taking any medications? Yes/No
If yes, please list: ____
Do you wear orthotics/she inserts? Yes/No
If yes, why type? ____

Women of child bearing age only. *Are you pregnant?* Yes/No If Yes, due date: ____________

Do you…?
Smoke: Yes/No if yes, how many cigarettes per day? ____________________________________
Drink Alcohol: Yes/No If yes, how much and what type each day? _________________________
Exercise: Yes/No Never Sometimes Frequently Regularly

Does anyone in your family have a similar health related problem? Yes/No
If yes, who? _____________________________________ What condition? __________________
What type of care are they receiving? ____
Is the treatment helping? Yes/No
May we contact them regarding their condition if we feel it would be helpful to your treatment? Yes/No

Patient Comments:

Signature of Patient, Parent or Guardian Date

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Review of Systems: Please indicate any personal history below

Constitutional Symptoms	NO	YES
Good general health lately		
Recent weight change		
Fever		
Fatigue		
Headaches		
Eyes	NO	YES
Eye disease or injury		
Wear glasses/contact lenses		
Blurred or double vision		
Ears/Nose/Mouth/Throat	NO	YES
Hearing loss or ringing		
Earaches or drainage		
Nose bleeds		
Mouth sores		
Bleeding Gums		
Bad Breath or bad taste		
Sore throat or voice change		
Swollen glands in neck		
Cardiovascular	NO	YES
Heart trouble		
Chest pain or angina pectoris		
Palpitation		
Shortness of breath w/walking or lying flat		
Swelling of feet, ankles, or hands		
Respiratory	NO	YES
Chronic or frequent coughs		
Spitting up blood		
Shortness of breath		
Wheezing		
Gastrointestinal	NO	YES
Loss of appetite		
Change in bowel movements		
Nausea or vomiting		
Painful bowel movements or constipation		
Rectal bleeding or blood in stool		
Abdominal pain		

Genitourinary	NO	YES
Frequent urination		
Burning or painful urination		
Blood in urine		
Change in force of strain when urinating		
Incontinence or dribbling		
Kidney stones		
Sexual difficulty		
Male—Testicle pain		
Female—pain with periods		
Female—vaginal discharge		
Female—number of pregnancies		
Female—number of miscarriages		
Female—date of last pap smear		
Musculoskeletal	NO	YES
Joint pain		
Joint stiffness or swelling		
Weakness of muscles or joints		
Muscle pain or cramps		
Back pain		
Cold extremities		
Difficulty in walking		
Integumentary (skin, breast)	NO	YES
Rash or itching		
Change in skin color		
Change in hair or nails		
Varicose veins		
Breast pain		
Breast lump		
Breast discharge		
Neurological	NO	YES
Frequent or recurring headaches		
Light headed or dizzy		
Convulsions or seizures		
Numbness or tingling sensations		
Tremors		
Paralysis		
Head injury		

Psychiatric	NO	YES
Memory loss or confusion		
Nervousness		
Depression		
Insomnia		
Endocrine	NO	YES
Glandular or hormone problem		
Excessive thirst or urination		
Heat or cold intolerance		
Skin becoming dryer		
Change in hat or glove size		
Hematologic/Lymphatic	NO	YES
Slow to heal after cuts		
Bleeding or bruising tendency		
Anemia		
Phlebitis		
Past transfusion		
Enlarged glands		
Allergic/Immunologic	NO	YES
History of skin reaction or other adverse reaction to:		
Penicillin or other antibiotics		
Morphine, Demerol, or other narcotics		
Novocain or other anesthetics		
Aspirin or other pain remedies		
Tetanus antitoxin or other serums		
Iodine, merthiolate or other antiseptic		
Other drugs/medication		
Known food allergies		
Environmental allergies		

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary Services I may need.

Signature of Patient, Parent or Guardian Date

Doctor's Review

Doctor's Signature Date

Informed Consent Document

PATIENT NAME____

To the patient: Please read this entire document prior to signing. It is important that you understand the information contained in this document. Please ask questions before you sign, if there is anything that is unclear.

The nature of the chiropractic adjustment:

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument on your body in such a way as to move your joints which may cause an audible "pop" or "click," i.e. as you may have experienced when you "crack" your knuckles. You May feel a sense of movement.

Analysis/Examination/Treatment

As part of the analysis, examination and treatment you are consenting to, initial the following procedures:

	Spinal manipulative therapy		Palpation		Vital signs
	Range of motion testing		Orthopedic testing		Basic neurological testing
	Muscle strength testing		Postural analysis		Cold Laser
	Hot/cold therapy		Radiographic Studies		
	Other (please explain):				

The material risks inherent in chiropractic adjustment:

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to fracture, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring:

Fractures are rare occurrences and generally result from some underlying weakness of the bone, which I check for during the taking of your history, during examination, and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and on in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options:

Other Treatment options for your condition may include:

- Self-administered, over the counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery
- Naturopaths, osteopaths, physical therapists

Informed Consent Document

If you choose to use one of the above noted "other treatment" options, You should be aware that there are risks and benefits of such options you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated:

Remaining untreated may allow the formation of adhesions and reduce mobility, which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

*****PLEASE SIGN AFTER YOU HAVE READ THE ABOVE UNLESS YOU HAVE QUESTIONS FOR THE DOCTOR*****

I have read ( ) or have had read to me ( ) the above explanation of the chiropractic adjustment and related treatment. I have discussed it with __________ and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated________________________________

____
Patient's Name

____
Signature

____
Signature of Parent or Guardian

Dated________________________________

____
Doctor's Name

____
Signature

Authorization and Assignment of Insurance Payment and Patient Consent for Treatment

In consideration of your undertaking to care for me, I agree to the following:

1. Deborah Kloby, D.C. is authorized to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.

2. I authorize the direct payment to Deborah Kloby, D.C. of any sum owed now or hereafter owed, by my attorney, out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for you services.

3. If my current policy prohibits direct payment to the doctor, then I hereby also direct and instruct the insurance company to make out the check to Deborah Kloby, D.C. and mail it as follows: Dr. Deborah Kloby, 32123 First AVE S., Suite A-4, Federal Way, WA 98003.

4. In the event any insurance company obligated by contractual agreement to make payment to me or to DCC for the charges made for your services refuses to make such payment upon demand by you, I hereby assign you and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance company(s) proceeds, whether it be all or part of what is due, I personally owe and agree to pay you.

5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monie s owed are paid in full. This authorization for assignment will be in continual effect until revoked by both parties.

6. This authorization will be in continual effect until revoked by both parties.

7. I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending doctor of chiropractic.

8. RELEASE OF INFORMATION: By signing this form, I am granting consent to Deborah Kloby, D.C. to use and disclose my protected health information for the purposes of treatment, payment and health care operations. Dr. Kloby's Notice of Privacy Practice provides more detailed information about how we may use and disclose this protected health information. I have a legal right to review the Notice of Privacy Practices before signing this consent, and I am encouraged by Dr. Kloby to read it in full. If Dr. Kloby changes the Notice, I may obtain a copy of it by telephoning the office at (253) 912-9653. I have a right to request or restrict how my protected health information is used for the purposes of treatment, payment or health care operations. Dr. Kloby is not required by law to grant this request. However, if Dr. Kloby does decide to grant my request, they are bound by this agreement. I have the right to revoke this consent in writing, except to the extent that Dr. Kloby has already used or disclosed my protected health information in reliance on this consent.

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION:
I certify that the information given by me in applying for payment under Title XVIII and/ or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or it intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

Signature Date

Deborah Kloby, D.C., PLLC,
32123 1st Ave S Ste A4, Federal Way, WA 98003
Office: 253-874-5008 Cell: 253-376-1009 Fax: 253-874-5024

Acknowledgement of Receipt of Notice of Privacy Practices

Deborah Kloby, D.C., PLLC,
Federal Way Chiropractic
32123 1st Ave S Ste A4, Federal Way, WA 98003
Office: 253-874-5008 Fax: 253-874-5024

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name: ____ Date of Birth: ____________________

I acknowledge that I have received and had the opportunity to review the Notice of Privacy Practices on the date below on behalf of Federal Way Chiropractor Center.

I understand that the Notice describes the uses and disclosures of my protected health information by Federal Way Chiropractic Center and informs me of my rights with respect to my protected health information.

____ ____
Patient's Signature or that of Legal Representative *Printed Name of Patient or that of Legal Representative*

____ ____
Today's Date *If Legal Representative, Indicate Relationship*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from the patient but it could not be obtained because:

- o The Patient Refused to sign.
- o Due to an emergency situation it was not possible to obtain an acknowledgement.
- o Communication barriers prohibited obtaining the acknowledgement.
- o Other (please specify: ____
  ____

Employee Name: ____ Today's Date: ____________________

Office Financial Policy

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care.

1. **If You Do Not Have Insurance: All payments are expected at the time of service or by an authorized payment plan.** Your personal balance may not exceed $100 at any time or care may be terminated. Our payment plans make care an affordable part of your family budget.

2. **If You Have Insurance: All deductibles and co-payments are expected at the time of service or by an authorized payment plan**. Your co-insurance balance may not exceed $100 or care may be terminated. Our payment plans make care an affordable part of your family budget.

3. **I understand that if I do not call and cancel appointments 24 hours in advance, that I will be charged a $25 for chiropractic non-cancellation fee, and/ or $35 fee for massage non-cancellation.**

We do not accept assignment for secondary insurance carriers but will be happy to provide you with a claim form to submit to your secondary carrier for your reimbursement.

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

____

Patient's Printed Name

____

Signature Date

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