Discover Health Chiropractic, PLLC

Reanna Plancich, D.C.

Confidential Information

Contact Information File # _____

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Hm Phone _____ Cell Phone _____Email _____

Gender **M F** Marital Status **S M D W P S** Date of Birth _____ Age _____

Children and Names Children (#_____) _____

Occupation _____ Employer _____

Employer Address _____ Employer Phone _____

Spouse Name _____ Spouse Employer _____

Emergency Contact _____ Relationship_____ Phone _____

Office Information

Were you referred to us? Yes No. Referral name_____

If yes, we would like to send the person who referred you a Thank You note. In an effort to maintain your privacy, we must obtain your permission. If you agree, please select yes and initial below:

_____ Yes, I permit the clinic to send a thank you card to the following individual who referred me.

Is your visit due to an injury? □ No □ Yes *If yes, circle one*: Auto Work Other _____

(If this visit is due to a work or auto injury, please see the receptionist for a special injury form)

List other doctors you use for your health care: _____

List any surgeries with dates: _____

List any fractures with dates: _____

List any prior x-rays with dates: _____

List any medications: _____

Women only- Are you pregnant? □ No □ Yes Date of last period_____/____/____ Due Date ____/_____/_____

Medicare or MVC Patients only-

If you have Medicare or have opened an MVC claim, please provide the information below.

I.D. # _____ Policy Group # _____

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment. It is my understanding that my credit may be checked if Discover Health Chiropractic, PLLC extends credit to me and I understand that if I suspend or terminate care and treatment, any fees for professional services rendered me will be immediately due and paid unless other arrangements are made. I hereby authorize the doctors at Discover Health Chiropractic, PLLC and whomever they may designate as their assistants; to administer treatments as they deem necessary and also authorize the release of any information acquired in the course of examination or treatment. I certify that the above information is true and correct.

Patient's (Parent or Guardian's) Signature: _____

Discover Health Chiropractic, PLLC

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Health History

Description of primary health concern(s): _____
_____

When (# of months or years) did you first start experiencing this issue? _____
_____

Why did this begin? _____
_____

You experience this issue: ▫ Constantly ▫ Daily ▫ Weekly ▫ Monthly ▫ Irregularly (explain) _____
_____

When present, how long does it last? (give a number or range) Hours____Days ____ Vary(explain) _____

What area is involved: _____

Please describe as: ▫ Ache ▫ Stiff ▫ Tight ▫ Spasm ▫ Sharp ▫ Numbness ▫ other(list) _____

When you have this issue, the discomfort/pain involved:
- ▫ is localized
- ▫ originates from another location (where) _____
- ▫ travels to another location (where) _____

Are there things that make the condition:

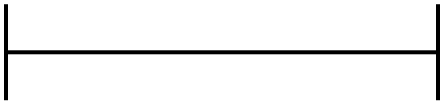
Better: _____

Worse: _____

On the scales below, please draw vertical lines (intersecting the horizontal lines) that represent the level of discomfort you have at the specified times:

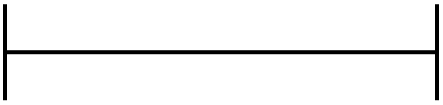
Rate your **average pain** in the **past week**:

No Pain Unbearable Pain



Rate your pain at it's **worst** in the **past week**:

No Pain Unbearable Pain

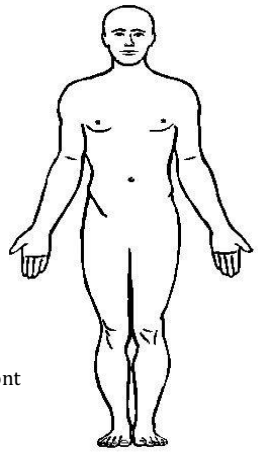


Identify your CURRENT symptomatic areas in your body by drawing the symbols on the figures below.

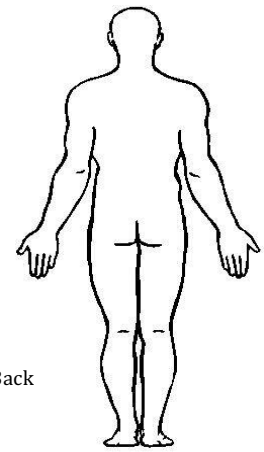
○ Circle areas of **Pain**

X "X" over areas of **Joint and Muscle Stiffness**

≈ Draw squiggly lines along the areas of **Numbness or Tingling**



Front



Back

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www.discoverchiropracticinseattle.com

Discover Health Chiropractic, PLLC

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Review of Systems **-Check all that apply-**

Sight
- ▫ Hyperopia (farsighted)
- ▫ Myopia (nearsighted)
- ▫ Blurred vision or presbyopia

Touch & Sensations
- ▫ Numbness
- ▫ Dizziness
- ▫ No sensation in a limb
- ▫ Tremors

Digestive System
- ▫ Bloating/gas
- ▫ Diarrhea
- ▫ Constipation
- ▫ Rapid weight gain
- ▫ Rapid weight loss
- ▫ Heartburn
- ▫ Ulcers

Cardiovascular System
- ▫ Low blood pressure
- ▫ High blood pressure
- ▫ Chest pain
- ▫ Fainting
- ▫ Swollen limbs
- ▫ Short breath
- ▫ Varicose veins

Hearing
- ▫ Tinnitus/ringing in ears
- ▫ Deafness (one ear or both)

Respiratory System
- ▫ Allergies
- ▫ Asthma
- ▫ Frequent colds
- ▫ Sinusitis
- ▫ Frequent coughing

Endocrine System
- ▫ Diabetes
- ▫ Hypoglycemia
- ▫ Thyroid problems
- ▫ Other _____

Skin
- ▫ Itching
- ▫ Rash/redness
- ▫ Cold hands/feet
- ▫ Nose bleeding

Musculo-Skeletal System
- ▫ Headaches
- ▫ Migraines
- ▫ Arm pain
- ▫ Leg pain
- ▫ Neck pain
- ▫ Mid-back pain
- ▫ Low-back pain
- ▫ Hand pain
- ▫ Foot pain

Reproductive System (Men)
- ▫ Testicular pain
- ▫ Erectile dysfunction
- ▫ Prostate problems

Reproductive System (Women)
- ▫ Abundant menses
- ▫ Menstrual pain
- ▫ Pre-Menopause symptoms

Urinary System
- ▫ Kidney Stones
- ▫ Frequent urge to urinate

Wellness
- ▫ Pertussis
- ▫ Fatigue
- ▫ Insomnia
- ▫ Irritability
- ▫ Depression

Childhood Diseases
- ▫ Measles
- ▫ Mumps
- ▫ Scarlet Fever
- ▫ Chickenpox

Infectious Diseases
- ▫ Cholera
- ▫ Yellow fever
- ▫ Typhoid fever
- ▫ AIDS/HIV
- ▫ Tuberculosis

Psychological Imbalances
- ▫ Alcoholism
- ▫ Anorexia/Bulimia
- ▫ Drug dependence
- ▫ Psychiatric care
- ▫ Suicide attempt

Blood Abnormalities
- ▫ High cholesterol
- ▫ Anemia

Cancer
- ▫ Intestinal
- ▫ Ovarian
- ▫ Prostate
- ▫ Skin
- ▫ Lung
- ▫ Breast

Chronic Diseases
- ▫ Rheumatoid Arthritis
- ▫ Emphysema
- ▫ Seizures
- ▫ Fibromyalgia
- ▫ Goiter
- ▫ Hepatitis
- ▫ Chronic Fatigue Syndrome
- ▫ Herniated disc
- ▫ Osteoporosis
- ▫ Parkinson's
- ▫ Multiple Sclerosis

NOTES: _____

_____

_____

_____

_____

_____

_____

_____

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Lifestyle

-Check your best answer-

1. Do you smoke? ▫ Everyday ▫ Occasionally ▫ Never

2. Have you ever smoked? ▫ >3 years ago ▫ >12 months ▫ Duration: _____-_____

3. Do you drink alcohol? ▫ Everyday ▫ Occasionally ▫ Never

4. Do you exercise or play sports? ▫ Regularly ▫ Occasionally ▫ Never

5. Do you drink coffee or caffeinated beverages? ▫ Everyday ▫ Occasionally ▫ Never

6. How many hours of sleep do you normally get? ▫ 6-8 ▫ 8-10 ▫ 10 or more

7. Do you eat regularly? ▫ 1 meal/day, sometimes 2 ▫ 2 meals/day, sometimes 3 ▫ 3 meals/day ▫ 3+/day

8. List any dietary restrictions: _____

9. Do you drink water regularly? ▫ Almost never ▫ 1-2 glasses ▫ 3-6 glasses ▫ 6 + glasses

10. How would you rate your stress level? ▫ Very stressed ▫ Stressed ▫ Slightly stressed ▫ No stress

11. Check your ethnicity: ▫ Caucasian ▫ Hispanic ▫ African American ▫ Asian ▫ Other _____

Accidents & Trauma

-Check your best answer-

1. Have you ever been in a motor vehicle collision? ▫ Never ▫ 1-2 small accidents ▫ A few small accidents ▫ 1-2 major accidents ▫ A few major accidents

2. Did you ever have a work injury? ▫ Never ▫ 1-2 small injuries ▫ A few small injuries ▫ 1-2 major injuries ▫ A few major injuries

3. Did you ever have a sports injury? ▫ Never ▫ 1-2 small injuries ▫ A few small injuries ▫ 1-2 major injuries ▫ A few major injuries

4. Have you ever had a concussion, a fall or a blow to the head?
▫ Never ▫ 1-2 small injuries ▫ A few small injuries ▫ 1-2 major injuries ▫ A few major injuries

Reasons for Consulting a Chiropractor

▫ Pain/Discomfort ▫ Motor vehicle accident
▫ Performance ▫ Work-related injury
▫ Posture ▫ Mobility
▫ Prevention ▫ Energy

Health Care Practitioners

Have you consulted these health professionals? -Please Circle all that apply-

1. Chiropractor 2. Medical Physician 3. Medical Specialist 4. Dentist

5. Physical Therapist 6. Naturopath 7. Osteopath 8. Acupuncturist

9. Homeopath 10. Massage Therapist 11. Podiatrist: 12. Traditional Chinese Practitioner

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INFORMED CONSENT

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

The undersigned patient requests and consents to examination and analysis by Dr. Reanna Plancich relating to the Atlas Subluxation Complex and its syndrome.

This requests includes, but is not limited to, permission for Dr. Reanna Plancich to perform Chiropractic examinations, radiographic studies, and adjustments as may be determined to be appropriate by her.

The undersigned patient understands that Dr. Reanna Plancich has concentrated her practice on the analysis and adjustment of the Atlas Subluxation Complex and its Syndrome. This is a stressor to the Central Nervous System and causes displacement of the patient's center of gravity from the vertical axis. This can also affect the peripheral nerves that radiate throughout the body. Spinal and body distortion can then develop. Adjustments are delivered only when the stressor at the brain stem level is detected. Adjustments are not necessarily given on every visit.

Adjustment of the Atlas Subluxation Complex does not address all aspects of health. I understand that Dr. Reanna Plancich strongly recommends that appropriate health care professionals be consulted for overall diagnosis as needed. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain and improving neurological functioning and overall well-being. Results are not guaranteed and there is no promise to cure. The success of any case depends on factors beyond the control of the Doctor of Chiropractic, including compliance by the patient with all instructions and directions.

As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, disc injuries, strokes, dislocations, strains, and sprains, soreness; a nearly always temporary symptom while your body undergoes therapeutic change. With respect to strokes, there is a rare but serious condition known as a cervical arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

The risks and possible consequences of the adjustments and the possibility of complications have been explained to me. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I thereby accept chiropractic care on this basis.

I, _____ have read and fully understand the above statements.
(PRINT NAME)

Patient's Signature: _____Date:_____

PHI Use and Disclosure Authorization

If you wish to have your medical or billing information released to family members you must fill out the information and sign below. We have permission to (please check all that apply):

- ❑ Leave messages on home phone or with household members about appointments, and test results.
- ❑ Leave messages on work phone about appointments, and test results.
- ❑ Leave messages on cell phone about appointments, and test results.
- ❑ Email appointment reminders
- ❑ Confirm appointments by phone or text

This authorization is effective through (check one):

- ❑ ___ /___ /___

- ❑ **NO EXPIRATION** unless revoked or terminated by the patient or the patient's personal representative.

I hereby authorize Discover Health Chiropractic, PLLC disclosure of my individually identifiable health information to the individuals listed below:

1. Name _____ Relationship to Patient _____

Authorization to:

- ❑ Disclose treatment plans and test results
- ❑ Billing information including statement balances
- ❑ Past and future Appointments
- ❑ Receive phone messages and/or email regarding appointments or test results
- ❑ Other _____

2. Name _____ Relationship to Patient _____

Authorization to:

- ❑ Disclose treatment plans and test results
- ❑ Billing information including statement balances
- ❑ Past and Future Appointments
- ❑ Receive Phone Messages or email regarding appointments or test results
- ❑ Other _____

I understand that I may revoke this authorization to disclose information at any time by notifying Discover Health Chiropractic, PLLC in writing (*Termination of Disclosure Form* provided upon request). If I choose to do so, I am aware that my revocation will not affect any actions taken by the clinic until the termination request is received in writing and processed.

Authorization to Disclose:

_____ _____
Patient Name (print) Patient's Date of Birth

_____ _____
Patient Signature Date

_____ _____
Signature of Personal Representative **Date**

Relationship to Patient: _____Driver's License Number: _____State_____

Discover Health Chiropractic, PLLC
Reanna Plancich, D.C.

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of Discover Health Chiropractic, PLLC's *Notice of Privacy Practices (NPP)*. I also understand that this practice has the right to change its *Notice of Privacy Practices* and that I may contact the practice at any time to obtain a current copy of the *Notice of Privacy Practices*.

_____ _____
Patient Name (print) Patient's Date of Birth

_____ _____
Patient Signature Date

If signed by a personal representative or legal guardian:

Name of Personal Representative: _____ _____
(Print) Date

Signature of Personal Representative: _____

Relationship to Patient: _____Driver's License Number: _____State____

Signing the *NPP Acknowledgement* does not mean that you have agreed to any special uses or disclosures (sharing) of your health records. Refusing to sign the acknowledgement does not prevent a provider or plan from using or disclosing health information as HIPAA permits. If you refuse to sign the acknowledgement, the provider must keep a record of this fact.

OFFICE USE ONLY
We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:
Attempt 1 Date _____ Staff_____

- ❑ Individual refused to sign.
- ❑ Communication barriers prohibited obtaining the acknowledgement.
- ❑ An emergency prevented us from obtaining acknowledgement.
- ❑ Other (Specify:)_____

Attempt 2 Date _____ Staff _____

- ❑ Individual refused to sign.
- ❑ Communication barriers prohibited obtaining the acknowledgement.
- ❑ An emergency prevented us from obtaining acknowledgement.
- ❑ Other (Specify:)_____

Payment is due at the time of service: We accept cash, check and Visa, Mastercard, or American Express

24-Hour Cancellation Policy and Appointment Contract:
There will be a $30.00 fee charged for missing or canceling an appointment without 24 hours notice. An insurance provider will not pay for these charges to your account. I understand that appointment times are given as estimated times that patients will be seen by the doctor. I understand the length of the office visit is based off the needs of each individual patient in the clinic and that there may be minimal or extended delays.

*Patient Signature:*_____ *Date:* _____

Motor Vehicle Collision:
We bill open Personal Injury Protection (PIP) claims only.

If your insurance has not paid their estimated balance due within 60 days of the date of service, you will be required to pay the amount in full. If the insurance company subsequently makes any payment, it will be reimbursed to you, or applied to your account, whichever you request.

You will need to work with your adjuster or your attorney to insure that they pay in full. We will hold you responsible for the difference between your insurer's payments and our fees.

If there is any dispute about any claim, for any reason, you will be required to pay the balance due, in full.

I assign directly to Dr. Reanna Plancich all benefits, otherwise payable to me for services rendered. I also authorize this office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions whether manual or electronic. I acknowledge that payment is due at the time of treatment. I accept full financial responsibility for all charges not covered by insurance.

*Patient Signature:*_____ *Date:* _____

Copies of Medical Records:
If at any point during or after your treatment you should desire a copy of your medical records, there will be a base fee of $25.00. There will be a fee of $1.12 per page for the first 30 pages and $0.84 per page for 31 pages or more. Records will be released after receipt of a HIPAA compliant release form and an original signature. Payment must be received within 30 days of release of records. The preparation may take up to four weeks. For any form that Dr. Reanna Plancich is asked and agrees to fill out, there will be a minimum fee of $25.00 payable prior to completion of the form. This fee will be billed directly to you and will not be filed with an insurance company or third party.

I have read the above information and agree to be responsible for all of the charges I incur in this office.

*Patient Signature:*_____ *Date:* _____