New Patient Health History Form

In order to provide you the best possible care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data

First Name | Last Name | Date | Email*

* Your email will NOT be shared with any 3d parties, and is used for occasional office announcements and promotions.

Mailing address

Address | City | State | Zip

Telephone (Work) | (home) | Referred By

Age | Birth Date | Number of Children

Occupation | Employer

Marital Status | Spouse's Name | Spouse's Occupation

Spouse's Employer | Spouse's Health Status

Emergency Contact | Phone

Current Complaints

Nature of Injury: ☐ Automobile* ☐ Work ☐ Other

Please describe:

Date if Injury | Date symptoms appeared

Have you ever had same condition? ○ No ○ Yes If yes, when?

List of other practitioners seen for this injury/condition

Have you ever been under chiropractic care? ○ No ○ Yes

If yes, please describe

Insurance Information

Name of party responsible for payment | Phone

Do you have health insurance? ○ No ○ Yes Name of company

*** If an auto accident, please provide:**

Insurance Company Name | Contact Person

Phone: | Claim #

Signatures

Name of the insured _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature _____ Date _____

Spouse's or guardian's signature _____ Date _____

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Medical History

Have you been treated for any conditions in the last year? ○ No ○ Yes

If yes, please describe

Date of last physical exam Is there a chance that you are pregnant? ○ No ○ Yes

Have you had X-rays taken? ○ No ○ Yes If Yes, where?

What medications are you taking and for what conditions (Please list dosage and amounts, etc)!

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency).

Have you ever:	No	Yes	Briefly Explain
Broken bones?	○	○	
Been hospitalized?	○	○	
Been in an auto accident?	○	○	
Had Sprains/Strains?	○	○	
Been struck unconscious?	○	○	
Had surgery?	○	○	

Family History

Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Do you experience pain every day?	○ No	○ Yes
Do your symptoms interfere with daily life?	○ No	○ Yes
Does pain wake you up at night?	○ No	○ Yes
Are your symptoms worse during certain times of the day?	○ No	○ Yes
Do changes in weather affect your symptoms?	○ No	○ Yes
Do you wear orthotics?	○ No	○ Yes
Do you take vitamin supplements?	○ No	○ Yes
What activities aggravate your symptoms?		

Habits	None	Light	Moderate	Heavy
Alcohol	○	○	○	○
Coffee	○	○	○	○
Tobacco	○	○	○	○
Drugs	○	○	○	○
Exercise	○	○	○	○
Sleep	○	○	○	○
Appetite	○	○	○	○
Soft Drinks	○	○	○	○
Water	○	○	○	○
Salty Foods	○	○	○	○
Sugary Foods	○	○	○	○
Artificial Sweeteners	○	○	○	○

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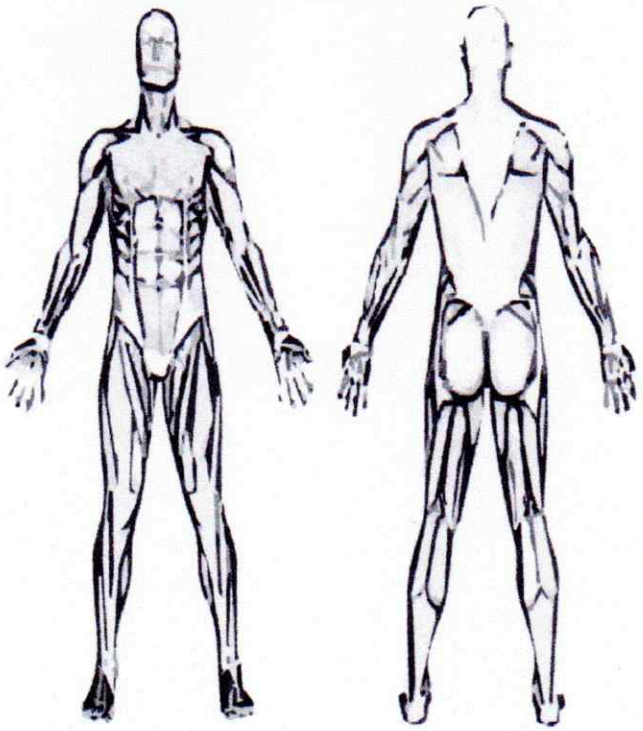
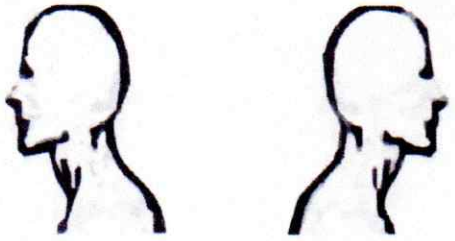
Have you ever suffered from:

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chest Pain/Conditions
- ☐ Cold Extremities
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ears Ring
- ☐ Excessive Menstruation
- ☐ Eye Pain or Difficulties
- ☐ Fatigue
- ☐ Frequent Urination
- ☐ Headache
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Hot Flashes
- ☐ Irregular Heart Beat
- ☐ Irregular Cycle
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Loss of memory
- ☐ Loss of balance
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Lumps In Breast
- ☐ Neck Pain or Stiffness
- ☐ Nervousness
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Polio
- ☐ Poor Posture
- ☐ Prostate Trouble
- ☐ Sciatica
- ☐ Shortness of breath
- ☐ Sinus Infection
- ☐ Sleep problems or Insomnia
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swelling of ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Other:

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache
B=Burning
N=Numbness
O=Other
P=Pins & Needles
S=Stabbing





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BELLEVUE NATURAL HEALTH

2687 151st Place NE #C3 Redmond, WA 98052 (p) 425.861.1112 (f) 425.861.1115

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1966 (HIPAA). I understand that this information can and will be used to:

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

I have been informed of my providers Notice of Privacy Practices, containing a description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of this notice, and I understand that my provider has the right to change this notice 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 protected health information is used or disclosed to carry out treatment, payment, or health care operations. I understand that you are not required to agree with my restrictions, but are required to abide by such restrictions.

Patient Signature: _____ Date: _____

Patient Name: _____

Relationship to patient: _____

Dependent family members also covered by this acknowledgment.

_____

_____

For office use only:

Patient refused to sign

Communication Barriers

Other_____

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES - CONTINUED

You have certain rights in regards to your protected health information, which you can exercise by presenting a written request to our Privacy Officer at the address listed below:

1. The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to requested restriction. If we do not agree to a restriction, we must abide by it unless you agree in writing to remove it.
2. The rights to access, inspect, and copy your protected health information, with limited exceptions. A reasonable Fee may be assessed.
3. The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
4. The right to request an amendment to your protected health information. We may, however, deny you request in certain situations.
5. The right to receive an accounting of disclosures of protected health information made outside of treatment, payment, or health care operations...or based on your previous authorization.
6. The right to obtain a paper copy of this notice from us upon request, even if you have agreed to receive the notice electronically.

For more information about our privacy practices, please contact:
Privacy Officer
2687 151st Place NE #C3
Redmond, WA 98052
(425) 861-1112

We are required by law to maintain the privacy of your protected health information, and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of January 2004, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our notice, and to make the new notice provisions effective for all protected health information that we maintain. Revisions will be posted on the effective date and you may request a written copy of the revised notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health and Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about HIPPA, or to file a complaint:
U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Ave. SW
Washington D.C. 20201
Toll free: 877-696-6775

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) require all health care records and other individually identifiable health information used or disclosed to us in any form whether electronically or on paper, or orally, be kept confidential. This federal law gives you the patient, significant new right to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information. As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purpose of treatment, payment, and health care operations.
Treatment: means providing, coordinating, or managing health care and related services by one or more health care providers or specialists involved in the continuation of your care.
Payment: means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we may disclose treatment information when billing an insurance company for your chiropractic services.
Health care operations: include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend, personal representative, or other individual to the extent necessary to help with your health care or payment for your health care. In the event of an emergency, or your incapacity, we will use our professional judgment in disclosing only the protected health information necessary to facilitate needed care. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards, and/or leaving messages at home and/or work. Your protected health information may also be used by our office to recommend treatment alternatives, or to provide you with information about health-related benefits and services that may be of interest to you. In addition, we may disclose your health information for public health oversight activities, judicial or administrative proceedings, in response to subpoena or court order, to military authorities of Armed Forces personnel, to federal officials for lawful intelligence, counterintelligence, and other national security activities, to correctional institutions or law enforcement officials, and/or report suspected abuse, neglect, or domestic violence. Any other uses or disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that request, except to the extent that we have already taken actions relying on your authorization.

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CLINIC POLICIES

Financial Policies

1. **Payment is due in full at the time of service.**
2. We accept the following forms of payment: cash or personal check, Visa and MasterCard credit cards.
3. Bellevue Natural Health Does Not bill healthcare insurance for services rendered.
   We will provide you with an insurance form to submit directly to your insurance company for possible reimbursement.
4. Bellevue Natural Health does bill for Personal Protection Injury directly to auto insurance companies.
5. Bellevue Natural Health is a non-participating provider for Medicare. We provide quality of life care which is not covered by Medicare.
6. The office manager may approve account balances. Active monthly payments are required. Accounts with balances 30 Days will be charged a service fee of 12% per year compounded monthly.
7. Any account where no payment has been received for sixty days may be sent to a third party collection agency. Any additional collection fees will be the responsibility of the patient.

Office Policies

1. Please be on time for your appointment . Being late, or last minute cancellations will cause severe scheduling disruptions, which can interfere with the quality of care you and other patients receive.
2. Please do not wear strong perfumes or colognes. We see many patients with allergies or respiratory conditions, and strong scents can impair their progress.
3. *If you need to spend extra time discussing health concerns with our doctor, please let our staff know, so we may schedule your appointment accordingly.*
4. Your health is our utmost concern. Please notify your doctor of any changes in your health status, regardless of the significance.

New Patient visit	$195.00	Medicare New Patient Visit	$125.00
Emergency Patient	125.00	Medicare Visit*	77.75
Regular Office Visit***	95.00	(*Note, 37.75 base plus 40.00 as needed)	
Cranial Visit	120.00		
Extended Time for Visit	75.00-95.00		

Note: X-rays may be needed before your first appointment. We can make an appointment for you and/or recommend where to obtain your X-rays which will be an additional cost from a separate office.

***Prepaid packages for adjustments and spinal decompression are available; ask your doctor or the front desk for details. Current package price is $750.00 for 10 visits. Medicare package price is $650.00 for 10 visits.

_____ _____

Signature Date

If patient is under the age of 18 years old, the parent/guardian must read and sign the following:

As parent/guardian of _____, I give permission for him/her to be treated at Bellevue Natural Health and will be responsible for any changes incurred.

_____ _____

Parent/Guardian Date

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TERMS OF ACCEPTANCE

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

Chiropractic has only one goal. 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.

***Adjustment**: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation.
***Health**: A state of optimal physical, mental and social well-being, not merely the absence of infirmity.
***Vertebral Subluxation**: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express it's maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you.

Regardless of what the disease is called, we do not offer to treat it. Our primary objective is to eliminate a major interference to the expression of the body's innate wisdom and offer recommendation to support that correction.

I have read and fully understand the above statements. All Questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

_____ _____

Signature Date

CONSENT TO EVALUATE AND ADJUST A MINOR CHILD:

As the parent or legal guardian of _____, I have read and fully understand The above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____

Signature Date