14575 Bel-Red Rd, Ste 100, Bellevue, WA 98007
Office: 425.641.8052 Fax: 425.641.8053 Web: BCAspine.com

BCA
BELLEVUE
CHIROPRACTIC
ASSOCIATES

PATIENT INFORMATION

Name ______________________________

Nickname ______________________________

Address ______________________________

City ______________ State ______ Zip ______

Patient's Gender Male ☐ Female ☐

Date of Birth ______________ SSN ______________

Employer ______________________________

Occupation ______________________________

Spouse Name ______________ #children ______

Spouse phone# ______________________________

Have you had previous chiropractic care? ______________

Primary Care Doctor ______________________________

Address/ City ______________________________

Dr. Phone # ______________________________

Who may we thank for referring you?

____

Relationship: ______________________________

Which phone number is best for day time use↓

Home Phone ______________________________ ☐

Work Phone ______________________________ ☐

Cell Phone ______________________________ ☐

E-mail address ______________________________

Preferred method of communication for patient reminders:

(circle) Email / Text / mail / phone

Emergency Contact ______________________________

Relation to You ______________________________

Phone Number ______________________________

*Required for **ALL patients** for compliance by Center for Medicare/Medicaid Services:*

Preferred Language: ______________________

Race (Check):

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White (Caucasian)
- ☐ Other ______________________
- ☐ Decline to Answer

Ethnicity (Check one):

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Decline to Answer

PATIENT AGREEMENT—PLEASE READ CAREFULLY

I authorize treatment of the patient named above and agree to pay all charges for such treatment that may or may not be covered by my insurance. I also authorize the provider to release any information to referring/ consulting physicians or other health care providers that may be necessary to facilitate care. I certify that a copy of this agreement shall be valid as the original.

Patient or Legal Guardian Signature

Date

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PATIENT HEALTH QUESTIONNAIRE

Name ______________________ Age ______ Sex _____ Date ____________

CHECK ALL BOXES THAT APPLY

Have you or any immediate family member ever been told you have:

	You	Family (relationship)
Cancer	☐	☐ ____________
High Blood Pressure	☐	☐ ____________
Diabetes	☐	☐ ____________
Heart Disease	☐	☐ ____________
Angina/chest Pain	☐	☐ ____________
Stroke	☐	☐ ____________
Arthritis	☐	☐ ____________
Back Pain	☐	☐ ____________

Do you have a history of:

- ☐ Shortness of Breath
- ☐ Allergies
- ☐ Asthma
- ☐ Breast Implants
- ☐ Bronchitis
- ☐ Kidney Disease/Stones
- ☐ Polio
- ☐ Emphysema
- ☐ Anemia
- ☐ Rheumatic Fever
- ☐ Ulcers
- ☐ Surgery

Women: are you pregnant? ☐ No ☐ Yes

CHECK ALL BOXES THAT APPLY

What current problem(s) do you experience:

- ☐ Nausea/Vomiting
- ☐ Fever/Chills/Sweats
- ☐ Numbness or Tingling
- ☐ Muscular Weakness
- ☐ Unexplained Weight Change
- ☐ Dizziness
- ☐ Night Pain
- ☐ Headaches
- ☐ Bowel or Bladder Changes

For this problem have you received treatment from:

- ☐ Orthopedist
- ☐ Physiatrist
- ☐ Neurosurgeon
- ☐ Physical Therapist
- ☐ Massage Therapist
- ☐ Osteopath
- ☐ Acupuncturist
- ☐ Psychologist
- ☐ Other Chiropractor
- ☐ Other ____________

Have you had any recent illness, including upper respiratory infections (flu) or urinary tract infections?

☐ No ☐ Yes

Describe: ______________________________

How often do you feel stress is a significant factor in your life?

☐ Never ☐ Seldom ☐ Regularly ☐ Always

Do you Smoke? (circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Do you drink alcohol?

☐ No ☐ Yes # of drinks per week? ________

Other comments:

____
____
____

Do you drink caffeine (coffee / tea / soda) ?

☐ No ☐ Yes # of cups per day? ________

List regular exercise/activity:

____
____

List all medications w/dosages and supplements: N/A

____________________ dosage: ________
____________________ dosage: ________
____________________ dosage: ________
____________________ dosage: ________
____________________ dosage: ________

List Medication Allergies & Reaction: N/A

____________________ reaction: ________
____________________ reaction: ________
____________________ reaction: ________

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CURRENT ASSESSMENT ( ) RE-EXAM ( ) NEW COND ( ) REACT

For Office Use: BP ____________
FRI____________

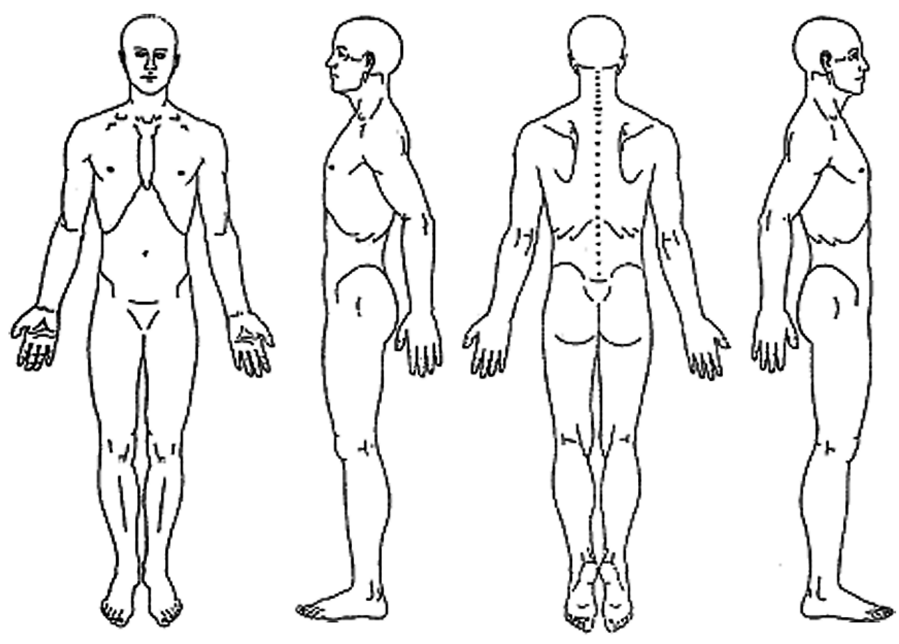
Name ________________________________ Age _____ Height _______ Weight ______ Date _________

Have you had any recent accidents or injuries? Yes No

If yes, please explain: ____

____

Pain Diagram: Mark the site of symptoms on the figures using the key below.



Circle the area of your Primary Concern:

Head - Neck - Mid Back - Low Back

Extremity ______________________

Frequency of Symptoms:

Constant | Intermittent

Range of Pain Intensity:

0 1 2 3 4 5 6 7 8 9 10

No Pain Extreme Pain

Office Notes:

** CONTINUE ON BACK →

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Oswestry Disability Questionnaire

Patient Name ______________________________ ***Date*** ______________

This questionnaire will give your provider information about how your condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your current problem.

Pain Intensity

(0) I have no pain at the moment.
(1) The pain is very mild at the moment.
(2) The pain is moderate at the moment.
(3) The pain is fairly severe at the moment.
(4) The pain is very severe at the moment.
(5) The pain is the worst imaginable at the moment.

Personal Care

(0) I can look after myself normally without causing extra pain
(1) I can look after myself normally but it causes extra pain.
(2) It is painful to look after myself and I am slow and careful.
(3) I need some help but manage most of my personal care.
(4) I need help every day in most aspects of self care.
(5) I do not get dressed, wash with difficulty and stay in bed.

Lifting

(0) I can lift heavy weights without extra pain.
(1) I can lift heavy weights but it causes extra pain.
(2) Pain prevents me from lifting heavy weights off the floor, but I can if they are in convenient places (e.g., on a table).
(3) Pain prevents me from lifting heavy weights but I can manage light to medium weights.
(4) I can only lift very light weights.
(5) I cannot lift or carry anything.

Walking

(0) Pain does not prevent me walking any distance.
(1) Pain prevents me from walking more than one mile.
(2) Pain prevents me from walking more than 1/2 mile.
(3) Pain prevents me from walking more than 1/4 mile.
(4) I can only walk using a cane or crutches.
(5) I am in bed most of the time and have to crawl to the toilet.

Sitting

(0) I can sit in any chair as long as I like.
(1) I can only sit in my favorite chair as long as I like.
(2) Pain prevents me from sitting more than 1 hour.
(3) Pain prevents me from sitting more than 1/2 hour.
(4) Pain prevents me from sitting more than ten minutes.
(5) Pain prevents me from sitting at all.

Standing

(0) I can stand as long as I want without extra pain.
(1) I can stand as long as I want but it gives me extra pain.
(2) Pain prevents me from standing for more than 1 hour.
(3) Pain prevents me from standing for more than 30 minutes.
(4) Pain prevents me from standing for more than 10 minutes.
(5) Pain prevents me from standing at all.

Sleeping

(0) My sleep is never disturbed by pain.
(1) My sleep is occasionally disturbed by pain.
(2) Because of pain, I have less than 6 hours sleep.
(3) Because of pain, I have less than 4 hours sleep.
(4) Because of pain, I have less than 2 hours sleep.
(5) Pain prevents me from sleeping at all.

Social Life

(0) My social life is normal and gives me no extra pain.
(1) My social life is normal, but increases the degree of pain.
(2) Pain has no significant effect on my social life apart from limiting my more energetic interests, (e.g., dancing, etc).
(3) Pain has restricted my social life and I do not go out as often.
(4) Pain has restricted my social life to my home.
(5) I have no social life because of pain.

Traveling

(0) I can travel anywhere without pain.
(1) I can travel anywhere but it gives me extra pain.
(2) Pain is bad but I manage journeys over two hours.
(3) Pain restricts me to journeys of less than one hour.
(4) Pain restricts me to short necessary journeys under 30 minutes.
(5) Pain prevents me from traveling except to receive treatment.

Employment / Homemaking

(0) My normal homemaking / job activities do not cause pain.
(1) My normal homemaking / job activities increase my pain, but I can still perform these tasks.
(2) I can perform most of my homemaking / job activities, except for more physically stressful activities.
(3) Pain prevents me from doing anything but light duties.
(4) Pain prevents me from doing even light duties.
(5) Pain prevents me from performing any job or homemaking chores.

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FINANCIAL POLICY

APPOINTMENTS: We realize unexpected situations occur. If your schedule does change and you have to cancel your appointment, please call with at least 24 hours notice so that we may offer that time to another person. If you will be late, please call immediately as we may need to reschedule your appointment. We do charge a $38 fee for missed or cancelled chiropractic appointments and $90 for massage appointments without 24 hours notice. This fee cannot be billed to your insurance company. If you miss 3 appointments without proper notice, all future appointments may be cancelled.

Initials: ______

FINANCIAL INFORMATION: You are financially responsible for all charges including but not limited to co-payments, deductibles and non-covered services. As a courtesy to patients we will verify your benefits and review them with you. However, it is always your responsibility to know your insurance benefits prior to treatment to prevent unexpected costs.

Initials: ______

HEALTH INSURANCE: Most health insurance companies require a portion of each visit to be patient responsibility, in the form of a deductible, co-pay and/or co-insurance amount and we ask for this payment at time of service.

Initials: ______

MEDICARE PATIENTS: We will bill Medicare. Medicare will only pay for services that it determines to be "reasonable and necessary". If Medicare denies any services, your secondary insurance will most likely not cover the services. Current Medicare regulations will not reimburse for the following services: exams, physical therapy, massage, x-rays, supports. Although they will usually pay for treatments, they may not pay for every treatment overall, or within a certain time period. Non-covered services will be charged directly to you and you will be responsible for payment. Please see Medicare Waiver.

Initials: ______

CASH PATIENTS: Payment for services is expected at the time of your visit unless other arrangements have been made. If we are not billing insurance, we can offer you a 20% discount when full payment is made at the time of each visit. We accept cash, checks, debit, Visa, and Mastercard.

Initials: ______

WORKERS COMPENSATION PATIENTS: We will bill your workers compensation carrier. An accepted claim pays 100% of treatment charges. If not accepted by workers comp, your health insurance will be billed.

Initials: ______

AUTO ACCIDENT PATIENTS: We will send PIP claims to your auto insurance company. These carriers usually pay 100% of billed charges. If your carrier does not, we will notify you. You will be responsible for unpaid charges. If you were a pedestrian, passenger, or bicyclist injured in an auto accident, we will send claims to the driver's auto insurance first. If you do not have PIP, your health insurance may pay the claims.

Initials: ______

By signing below you hereby authorize your insurance benefits to be paid directly to BCA. You agree to not withhold or delay payment if your insurance company denies payment on any of your charges. In the event it should become necessary to forward your unpaid balance to a collection agency, you agree to pay interest and collection fees. If legal action is taken against this account, you agree to pay all reasonable attorney fees, filing fees and any other costs associated with this action. Checks returned without sufficient funds will be charged a $35.00 fee.

Balances unpaid after 60 days will accrue a 1.5% (18% annually) finance charge each billing cycle. Balances unpaid after 60 days must have payment arrangements with our billing office. Balances unpaid after 90 days will be turned over to collections.

Patient Name	Date
X	
Signature	Person Responsible for bill (if patient is under 18 years)

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INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

Before beginning treatment it is our office policy to inform you of what to expect, possible complications of chiropractic, as well as complications of other approaches. Remember that all forms of treatment, including non-treatment, have associated risks. If you have any questions please be sure to ask the doctor.

WHAT TO EXPECT:

The treatment at our office will consist of adjustments/manipulation of the joints and soft tissues using hands and/or a mechanical instrument. You may feel joint movements and you may hear joint clicks or other noises. Physical therapy methods along with therapeutic exercise may also be used.

CHIROPRACTIC RISKS:

Chiropractic treatment is one of the safest methods of treating back pain. Nevertheless, unexpected problems can occur. Minor problems such as soreness and stiffness may occur in the beginning of the treatment plan. Slightly more serious problems are local burns from heat generated physical therapy equipment. More significant problems such as fracture of weakened bone, sprains and disc injuries are rare. A stroke temporally linked to neck adjustments is an extremely rare complication. Stroke has also been linked to ordinary activities such as hair shampooing or gazing at the stars.

OTHER TREATMENTS AND RISKS:

Medications: Many commonly used medications such as NSAIDs (ex: Advil, Aleve) or Tylenol carry risks of tissue damage including stomach ulcers or kidney/liver damage. This damage can occur quickly and may be irreversible. There is a significant higher risk of developing a serious complication with NSAIDs Pain medications are habit forming and may mask pain allowing further tissue damage.

Surgery: Surgery is the treatment of choice in less than 1% of back pain patients. Your doctor has screened for surgical “red flags” and will refer you for a surgical opinion if indicated. Clinical results of surgery for mechanical back pain have been disappointing and expose you to unnecessary hospital and medication risks.

Rest/Non-treatment: Long periods of rest has been shown to increase the likelihood of recurrence of back episodes and make chronic pain more likely. Likewise, non-treatment may cause permanent mechanical problems to develop, causing future back problems.

Patient Name	Date
Patient or Legal Guardian Signature	Minor Release

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ACKNOWLEDGEMENT OF PRIVACY RIGHTS

My signature confirms that I have been informed that I have rights to privacy regarding my protected health information, and I have been given the opportunity to review this office's NOTICE OF PRIVACY PRACTICES as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations.
- Provide & coordinate treatment among health care providers who may be involved in my care.

(Optional) I authorize the following person(s) to obtain my medical information:

____

____

____

Patient Name	Date
Patient or Legal Guardian Signature	Relationship to Patient

FOR OFFICE USE ONLY:

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

- ☐ Communication barriers
- ☐ Emergency situation
- ☐ The patient refused to sign
- ☐ Other