

Mountain View Chiropractic and Wellness Center
Chiropractic • Naturopathic Medicine • Acupuncture • Massage

19102 State Route 410 EAST #A • Bonney Lake, WA 98391
Ph 253-863-6378 • Fax 253-863-6429

WELCOME

The doctors and staff of Mountain View Chiropractic and Wellness Center welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical exam to decide if we can assist you. If we do not believe that your condition will respond to therapies we offer, we will not accept you as a patient but will refer you to another healthcare provider as appropriate.

INSURANCE

This office will process your insurance forms upon request. We will do our utmost to provided sufficient information to your carrier to provide payment for your treatment. We have found that in some instances, however, insurance companies will deny or reduce payment despite our best efforts to demonstrate the necessity for care. In the event that full payment is not made for any reason, you must understand that you are responsible for making full payment.

PATIENT IDENTIFICATION

Name _____
(Last) (First) (Name/nickname preference?)

Address _____
(Mailing) (City) (State) (Zip)

Address _____
(Physical, if different than above)

Social Security # _____ **Date of Birth** _____ **Age** _____

Home Ph # _____ **Work #** _____ **Cell #** _____

Email _____ **Name of Parent if a Minor** _____

How did you hear about us, or did someone refer you? _____

Emergency Contact

Name _____ **Relationship** _____ **Ph #** _____

ACCEPTANCE AS A PATIENT

I understand and agree that the doctors of Mountain View Chiropractic and Wellness Center have the right to refuse to accept me as a patient at any time before treatment. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

SIGNATURE _____ **Date** _____

PRINT YOUR NAME HERE : _____

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INFORMED CONSENT FOR TREATMENT

Chiropractic, Naturopathic Medicine, Acupuncture and Massage are considered safe and effective methods of care. Occasionally, however, complications can arise. Any procedure intended to help may have complications, and while the chances of experiencing complications are small, it is the practice of this clinic to inform our patients of them.

I _____ consent to the following examination and therapeutic treatment procedures as necessary to facilitate my diagnosis and treatment:

Chiropractic Care: including spinal adjustment; heat and/or ice application; traction; laser, electro and manual muscle therapy; radiography and xray

Naturopathic Medicine: including **Common Diagnostic Procedures** (venipuncture, PAP smears, lab tests); Minor Office Procedures (wound dressing, ear cleansing); **Medicinal Use of Nutrition** (therapeutic nutrition, nutritional supplements and I.M. Vitamin injections); **Botanical Medicine** (botanical substances prescribed as teas, alcohol-based tinctures, capsules, tablets, creams, plaster, or suppositories); **Homeopathic Medicine** (the use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.; Lifestyle Counseling and Hygiene (diet/nutrition therapy and promotion of wellness, including recommendations for exercise, sleep, stress reduction and balancing of work and social activities... Psychological Counseling; Contraception; Immunization; Certain Prescription Drugs (antibiotics, hormones such as thyroid and bioidentical hormones, certain naturally derived drugs)

Acupuncture: including needling, electro-acupuncture, cupping, tui na (chinese therapeutic massage); moxabustion (herbal heat application) and other specialized treatments.

Massage: including various styles of therapeutic massage and various specialized treatments (body wraps, hot stone massage, etc.)

I recognize the potential risks and benefits of these procedures as prescribed below:

Potential risks: including but not limited to soreness, bruising, inflammation, soft tissue injury, dizziness, burns, allergic reactions to prescribed herbs and supplements, side effect of medicines, injury from injections, venipuncture or other procedures, temporary increase in fatigue, and temporary worsening of symptoms. More serious complications are extremely rare and their association with spinal adjustments (manipulation) is debated.

Potential Benefits: restoration of health and the body's maximal functional capacity without the use of drugs and surgery (in some cases, certain drugs may be prescribed if appropriate). Relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant Women: All female patients must alert their doctor if they know or suspect that they are pregnant, as some of the therapies used could present a risk to the pregnancy.

ACKNOWLEDGEMENT OF PRIVACY RIGHTS

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or myself, or unless law requires it. I understand that I may look at my medical record and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept no more than 10 years after the date of my last treatment. I understand that my practitioner will answer any questions I have.

Signature of Patient / Guardian Date

Description of Guardian's Authority (e.g. Parent of minor)

MOUNTAIN VIEW CHIROPRACTIC, P.L.L.C.
19102 STATE ROUTE 410 EAST #A BONNEY LAKE WA 98391

CONSENT FORM & ACKNOWLEDGEMENT OF PRIVACY RIGHTS

To Our Patients:

Chiropractic examination and therapeutic procedures (including spinal adjustment, heat, ice application, traction, laser and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. 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 are estimated to be in the range of .5-2 incidents per million adjustments for adjustments of the neck, and 1 per million for adjustments of the low back. Additional information on side-effects and complications is available upon request.

I, _____ consent to Mountain View Chiropractic Clinic (MVCC) use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for the purposes relating to the payment of services rendered to me, and for MVCC's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that MVCC diagnosis or treatment of me maybe conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by MVCC, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of MVCC, but that MVCC is not required to agree to these restrictions. However, if MVCC agrees to restriction that I request, the restriction is binding on MVCC.

I understand I have a right to review MVCC Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or MVCC has acted in reliance of this consent.

Signature of Patient/Personal Representative/Guardian

Date

Description of Personal Representative's Authority

Mountain View Chiropractic Clinic and Wellness Center
19102 SR 410 East #A Bonney Lake WA 98391

Personal Health History

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.

(Name) _____

(Date of Birth) _____

(Age) _____

(Today's Date) _____

Circle all conditions you currently have or have had. We need your complete health history.

Muscle / Joint

- ± Arthritis
- ± Bursitis
- ± Foot trouble
- ± Hernia
- ± Low back pain
- ± Lumbago
- ± Neck pain, stiffness
- ± Pain between shoulders

General

- ± Allergy
- ± Chills
- ± Convulsions
- ± Dizziness
- ± Fainting
- ± Fatigue
- ± Fever
- ± Headache
- ± Loss of sleep
- ± Loss of weight
- ± Nervousness, depression
- ± Neuralgia
- ± Numbness
- ± Sweats
- ± Tremors

Cardiovascular

- ± Hardening of arteries
- ± High blood pressure
- ± Low blood pressure
- ± Pain over heart
- ± Poor circulation
- ± Rapid heartbeat
- ± Slow heartbeat
- ± Swelling of ankles

Genitourinary

- ± Bed-wetting
- ± Blood in urine
- ± Frequent urination
- ± Lack of kidney control
- ± Kidney infection
- ± Painful urination
- ± Prostate trouble
- ± Pus in urine

Eye, Ear, Nose and Throat

- ± Asthma
- ± Colds
- ± Crossed eyes
- ± Deafness
- ± Dental decay
- ± Earache
- ± Ear discharge
- ± Ear noise
- ± Enlarged glands
- ± Enlarged thyroid
- ± Eye pain
- ± Failing vision
- ± Far sightedness
- ± Gum trouble
- ± Hay fever
- ± Hoarseness
- ± Nasal obstruction
- ± Near sightedness
- ± Nose bleeds
- ± Sinus infection
- ± Sore throat
- ± Tonsillitis

Gastrointestinal

- ± Belching or gas
- ± Colitis
- ± Colon trouble
- ± Constipation
- ± Diarrhea
- ± Difficult digestion
- ± Bloating abdomen
- ± Excessive hunger
- ± Gallbladder trouble
- ± Hemorrhoids
- ± Intestinal worms
- ± Jaundice
- ± Liver trouble
- ± Nausea ± Lumps in breast
- ± Pain over stomach
- ± Poor appetite
- ± Vomiting
- ± Vomiting of blood

Skin

- ± Boils
- ± Bruise easily
- ± Dryness
- ± Varicose veins
- ± Itching
- ± Skin eruptions (rash)

Pain or numbness in

- ± Shoulders
- ± Arms
- ± Elbows
- ± Hands
- ± Hips
- ± Legs
- ± Knees
- ± Feet
- ± Painful tailbone
- ± Poor posture
- ± Sciatica
- ± Spinal curvature
- ± Swollen joints

Respiratory

- ± Chest pain
- ± Chronic cough
- ± Difficult breathing
- ± Spitting up blood
- ± Spitting up phlegm
- ± Wheezing

Women only

- ± Congested breasts
- ± Cramps or backache
- ± Excess menstrual flow
- ± Hot flashes
- ± Irregular cycle
- ± Menopause
- ± Painful menstruation
- ± Vaginal discharge

Check any of the following conditions you currently have or have had:

- ± Appendicitis
- ± Arteriosclerosis
- ± Cholera
- ± Cold sores
- ± Edema
- ± Emphysema
- ± Fever blisters
- ± Goiter
- ± Herpes
- ± Influenza
- ± Malaria
- ± Miscarriage
- ± Pacemaker
- ± Pleurisy
- ± Pneumonia
- ± Typhoid fever

Are you pregnant? ± Yes ± No

If yes, how many months? _____

How many children do you have? _____

Have you seen a chiropractor before? ± Yes ± No If yes, how long ago? _____

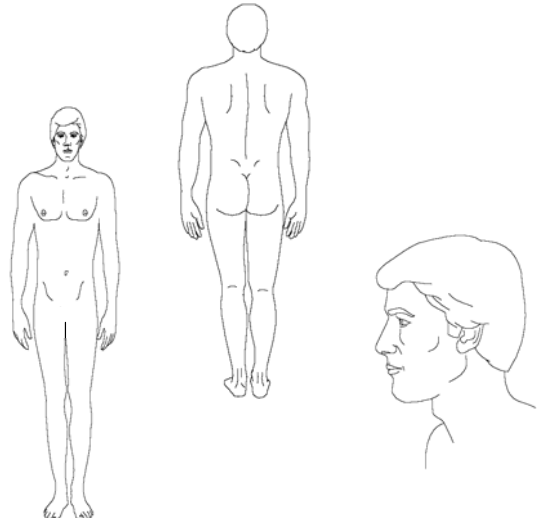
For what reason? _____

Are you under the care of a physician? ± Yes ± No If yes, for what reason? _____

Do you wear? ± heel lifts ± sole lifts ± inner soles

When did you last have spinal x-ray? Never 0-6 mos 6-18 mos Longer?

Please circle areas of pain



PRINT YOUR NAME HERE : _____

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CONFIDENTIAL HEALTH HISTORY

Name: _____ **Birthdate:** _____ **Date:** ____/____/____

Place of birth	Education
Relationship status	Occupation
Hobbies	Previous occupations
Exercise/recreation	Height
Weight Weight 1 year ago Maximum Weight	
Date of last Physical Exam	Date of last Eye exam
Date of last colonoscopy	Date of last Prostate exam
Date of last full bloodwork	Date of last Bone Density testing
Date of last Mammogram	Date of last Dental Exam
Describe all serious accidents, severe injuries, head injury, fractures or broken bones (include date occurred): <input type="checkbox"/> None _____ _____ _____	List all serious illnesses, operations, and other operations, and other hospitalizations you have experienced and indicate year these occurred: <input type="checkbox"/> None _____ _____ _____

CHIEF COMPLAINTS: Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:

1. _____
2. _____
3. _____
4. _____

How long have you had this/these condition(s)? _____ **Is it/ Are they getting worse?** _____
Does you condition bother you during work / sleep / other? _____ **What seemed to be the initial cause of your condition(s)** _____

MEDICATION: (Include everything you have taken or are taking: pills, tablets, liquids, ointments, suppositories, etc)

Antacids	Antibiotic/Antifungal	Antidepressants	Antidiabetic/Insulin
Aspirin/Tylenol	Chemotherapy	Cortisone	Anti-Inflammatories
Heart Medications	High Blood Pressure	Hormones	Laxatives
Lithium	Oral Contraceptives	Radiation	Recreational Drugs
Relaxants/Sleeping Pills	Thyroid	Ulcer Medication	Other

LIST VITAMINS, MINERALS, HERBS, DOSES TAKEN:

ALLERGIES:

Drugs:			
Foods:			
Environmental Sources:			
Other:			

CIRCLE IF YOU:

Diet often	Are under excessive stress	Are exposed to chemicals at work	Do not sleep well
Eating Disorder	Recreational Drugs	Spiritual Practice, please indicate →	

DO YOU DRINK OR CONSUME:

Alcohol	Candy	Carbonated beverages	Cheese
Cigarettes	Coffee	Meals at fast food restaurants	Fried foods
Luncheon meats	Margarine	Meat eater	Milk or Ice Cream
Refined sugar	Saccharine or Aspartame	Chew tobacco	Butter

DIET: *please list typical foods consumed on a regular basis*

Breakfast: _____
 Lunch: _____
 Dinner: _____
 Snacks: _____
 Fluids: _____
 Alcohol: _____

PAST MEDICAL HISTORY

Measles	no yes	Hives or Eczema	no yes	Infectious Mono	no yes
Mumps	no yes	Tuberculosis	no yes	Rheumatic Fever	no yes
Chickenpox	no yes	Diabetes	no yes	Mitral Valve Prolapse	no yes
Whooping Cough	no yes	Cancer	no yes	Stroke	no yes
Scarlet Fever	no yes	Polio	no yes	Hepatitis	no yes
Diphtheria	no yes	Glaucoma	no yes	Thyroid Disease	no yes
Smallpox	no yes	Hernia	no yes	AIDS or HIV+	no yes
Blood Transfusions	no yes	Kidney Disease	no yes	Anemia	no yes
Heart Disease	no yes	Bleeding tendency	no yes	Depression	no yes
Venereal Disease (STD's)	no yes	Anxiety	no yes		

Any other disease or emotional disorders (please list) _____

FAMILY HISTORY:

PRINT YOUR NAME HERE : _____

Who (self or list close blood relative) Who (self or list close blood relative)

Alcohol or Drug Problem		HIV	
Ulcers		Kidney Disease	
Anemia		Leukemia	
Ankylosing Spondilitis		Mental Illness	
Asthma		Migraine Headaches	
Autoimmune disorders		Multiple Sclerosis	
Cancer		Muscular Dystrophy	
Chronic Lung Disease		Obesity	
Diabetes		Osteoporosis	
Eczema		Psoriasis	
Epilepsy		Parkinson's disease	
Glaucoma		Rheumatoid Arthritis	
Gout		Stroke	
Heart Disease		Thyroid Disease	
Hepatitis		Tuberculosis	
High Cholesterol/Blood Pressure		Other	

Present age / Age at death If living, health (good, fair, poor) If deceased, cause of death

Father: _____

Mother: _____

Siblings: _____

Spouse: _____

Children: _____

Please list any other information you think is important:



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PATIENT RIGHTS

1. Receive clear and complete information about your care and participate in the decisions concerning your treatment. If you have concerns about the front desk, insurance or billing, please contact us.
2. Be treated with respect and courtesy by all those involved in providing care and information.
3. Ensured privacy during interviews and examinations. All information about a patient's care and records will be treated in a confidential manner.
4. Voice concerns about your care, or about the manner in which you were treated by the doctor, intern or staff. If you have concerns, please contact us right away.

PATIENT RESPONSIBILITIES

1. Be as accurate and complete as possible when providing information about your medical history or condition.
2. Cooperate in following instructions given to you by those providing your health care.
3. Read and cooperate with the instructions provided by your doctor.
4. Make payments on time. Read and sign the attached Financial Policy.
5. Ask for clarification about any aspect of your health care benefits that you do not fully understand.
6. Keep scheduled appointments or give adequate notice of delay or cancellation.
7. Treat those caring for you with respect and courtesy.

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CLINIC FINANCIAL POLICY

1. All payments are due at the time of service, unless special arrangements have been agreed upon prior to the visit.
2. All co-pay will be due at the time of service, once your insurance coverage has been verified and we have established what your responsibility is.
3. As a courtesy to our patients, we will bill your insurance company for you. Please keep in mind that if there is a discrepancy, we will let you know as soon as possible, however we will not get involved with any dispute between you and your insurance carrier.
4. If you have a credit balance, we will reimburse you after payment has been received.
5. All supplements/vitamins, lab tests, supports and other supplies must be paid for at the time they are received.
6. All workers' compensation cases will be billed directly to the insurance company, providing the appropriate paperwork has been filled out and a claim is filed. Please keep in mind that if your claim is denied you are responsible for prompt payment of your account.
7. Personal injury and auto accident cases will be billed to your auto insurance company, providing that a claim has been filed and the appropriate paper work has been completed.
8. Keep in mind we do not do third party billing to other insurance companies.
9. If you choose not to file a claim with your auto insurance company, or are uninsured, your account will be treated as a cash account, and all fees will be due at the time of service.
10. Generally, supplements/vitamins, lab tests, supports and other supplies may not be covered by insurance companies and **must be paid for at the time they are received.** Should your insurance company pay, we will reimburse you for the amount paid.

CLINIC LATE CANCELLATION FEE POLICY

Your appointment times have been reserved for you. In order to offer timely and optimal care for all our patients, we request 24 hours notice for cancellation of visits. Kindly provide us notice by calling the front desk. Please always leave a message if your call goes directly to our voice mail. ***Please note that in the case of *massage* appointments you will be charged a \$35 fee for any visit cancellations without 24 hours notice.***

I _____ have read and understand the above clinic financial and fee policies.

Patient / Guardian Signature Date