Discover Health Chiropractic, PLLC

Reanna Plancich, D.C.

Confidential Information

Contact Information File # _____

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Hm Phone _____ Cell Phone _____Email _____

Sex **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

Who referred you to our office? _____

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 _____/_____/_____

Insurance Information

Do you have insurance? □ Yes □ No Company _____

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: _____

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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:

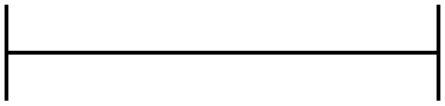
Better: _____

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:

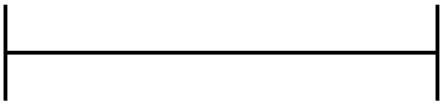
Rate your **average pain** in the **past week**:

No Pain Unbearable Pain



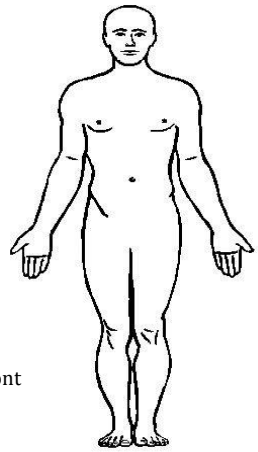
Rate your pain at it's **worst** in the **past week**:

No Pain Unbearable Pain

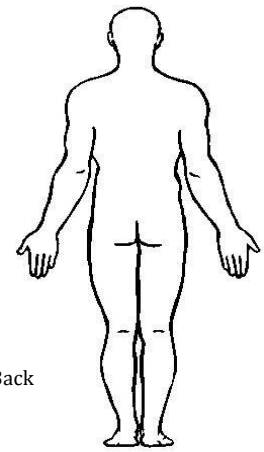


Identify your CURRENT symptomatic areas in your body by drawing the symbols on the figures below.

○ 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

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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 ▫ Other: _____

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
- ▫ Performance
- ▫ Posture
- ▫ Prevention
- ▫ Motor vehicle accident
- ▫ Work-related injury
- ▫ Mobility
- ▫ 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:_____

Notices 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

Discover Health Chiropractic, PLLC is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations (example)

> "On occasion, it may be necessary to seek consultation regarding your treatment from other health care providers associated with Discover Health Chiropractic, PLLC"
>
> "It is our policy to provide a substitute health care provider, authorized by Discover Health Chiropractic, PLLC to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness or other emergency situation."

Due to the nature of Discover Health Chiropractic's open adjustment areas, others may overhear conversations between the doctor and patient although every effort will be made to avoid loss of confidentially. At any time you may request a private consultation with the doctor.

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

> "As a courtesy to our patients, we will submit an itemized statement to your insurance center for the purpose of payment to Discover Health Chiropractic, PLLC for health care services rendered. If you pay for your health care services personally we will, as a courtesy to you, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information including diagnosis, date of injury or condition, and codes which may describe the health care services received."

Worker's Compensation

We may disclose your health information as necessary to comply with State Workers Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member or another person responsible for your care about your medical condition or in the event of an emergency or your death.

Public Health

As required by law, we may disclose your health information to public health authorities for the purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infectious exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement

We may disclose your health information to law enforcement officials for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order of subpoena, and other law enforcement purposes.

Deceased Persons

We may disclose your health information to coroners or medical examiners.

Organ Donation

We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

Public Safety
It may be necessary to disclose your health information to appropriate persons in order to prevent or lesson a serious and imminent threat to the health or safety of a particular person or to the general public
Specialized Government Agencies
We may disclose your health information for military, national security, prisoner and government benefits purposes.
Marketing
We may contact you for marketing purposes or fundraising purposes, as described below: (example)
"As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not home, we will leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

"It is our practice to participate in charitable events to raise awareness, food donations, etc. During these times, we may need to send you a letter, post card or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Discover Health Chiropractic, PLLC sponsored fund-raising events."
Change of Ownership
In the event that Discover Health Chiropractic, PLLC is sold or merged with another organization, your health information will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Discover Health Chiropractic, PLLC is not required to agree to the restriction you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and receive a copy of your health information.
- You have the right to request that Discover Health Chiropractic, PLLC amend your protected health information. Please be advised, however, that Discover Health Chiropractic, PLLC is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have the right to receive an accounting of disclosures of your protected health information made by Discover Health Chiropractic, PLLC
- You have the right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices
Discover Health Chiropractic, PLLC reserves the right to amend this Notice of Privacy Practices at any time in the future and will make the new provisions effective for all the information that it maintains. Until such an amendment is made, Discover Health Chiropractic, PLLC is required by law to comply with this Notice.
Discover Health Chiropractic, PLLC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights
Questions and Complaints:
You have the right to file a complaint if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our office by contacting 206-577-3588. If you feel we may have violated you privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us (in writing). We support your right to privacy and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of HHS.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to: DHHS, Office of Civil Rights: 200 Independence Avenue, SW, Room 509F HHH Building, Washington, D.C. 20201
I have read the Privacy Notice and understand my rights contained in the notice

By way of my signature, I provide Discover Health Chiropractic, PLLC with my authorization and consent to use and disclose my protected health care information for the purposes of the treatment, payment and health care operations as described in the Privacy Notice

_____ _____
Patient's Name (print) Date

_____ _____
Patient's Signature Date

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:* _____