PEARSON
CHIROPRACTIC & REHABILITATION

pearsonchiropractic.com

WELCOME

The doctors and staff of Pearson Chiropractic & Rehabilitation 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 chiropractic care, we will not accept you as a patient, but will refer you to another health care provider, if appropriate. PLEASE PRINT CLEARLY!

PATIENT INFORMATION (PLEASE PRINT)

Name (First, Middle, Last) _____ Name you like to be called _____ Date of Birth _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Race:_____

Address _____ City _____ State _____ ZIP _____

Social Security Number **(REQUIRED)** _____ Home Phone _____ Mobile Phone _____ Work Phone _____

Emial Address **(REQUIRED)** _____

EMPLOYMENT INFORMATION

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Part Time Student ☐ Full Time Student ☐ Other_____

Employer _____ Occupation _____

RESPONSIBLE PARTY INFORMATION - If you are over age 18, please indicate self as responsible party

Name (if other than self) _____ Relationship to Patient _____ Responsible Party Phone _____

Responsible Party Address _____ City _____ State _____ ZIP _____

EMERGENCY CONTACT

Emergency Contact Name _____ Relationship to Patient _____ Emergency Contact Phone _____

INFORMATION ABOUT YOUR INJURY OR ILLNESS

Is your illness/injury related to any of the following?

☐ Employment ☐ Emergency ☐ Accident ☐ Auto Accident—state accident date _____

If employment related, has your employer been notified? ☐ Yes ☐ No

REFERRAL INFORMATION

How were you referred to our office? ☐ By an Attorney ☐ By a Doctor ☐ By a Patient ☐ On Social Media

☐ Google ☐ Pearson Website ☐ Office Location ☐ Other _____

Name of Referral Source _____

ACCEPTANCE AS A PATIENT

I understand and agree that the doctors of Pearson Chiropractic & Rehabilitation have the right to refuse to accept me as a patient at any time before treatment begins. 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. By submitting your phone number, you are authorizing us (opting in) to send you text messages and notifications. Message/data rates apply. Reply STOP2END to unsubscribe to a message sent from us.

Signature _____ Date _____

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PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient _____ Date _____

Signature _____

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FINANCIAL POLICY

The following is an explanation of our clinic policy. We believe that a clear definition of our policy will allow us both to concentrate on the big issue: re-establishing, retaining and maintaining your health. We will be happy to answer any questions you have regarding our policy, your account and your insurance coverage.

Payments
At Pearson Chiropractic your health care needs are our primary concern. We do not want finances to get in the way of you getting the health care that you need. Policies are in place in an attempt to assist you in meeting your financial obligations without increasing stress in your life.

- **If you do not have insurance ALL payments are expected at the time of service. Prepayments are also allowed.**
- **If you have insurance ALL COPAYS & CO-INSURANCE are due at time of service. By taking care of this while you are in the office the need for an invoice is minimized.**
- **There will be a 1% finance charge added to all balances after 60 days. Maximum charge is 12% per year.**
- **There will be a $25.00 charge on all returned checks.**
- **If you need any additional documentation other than a receipt please feel free to ask the front desk as we are able to provide that to you at no additional charge.**

Insurance Coverage
Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment. If claims denial is received after the insurance has processed, the balance will be Patient Responsibility.

Statements are sent via text or e-mail. We will not bill your health insurance for personal injury claims unless it is specified on the Motor Vehicle Accident authorization paperwork.

X-rays
We will release your X-rays to another doctor only after you sign a release/transfer form & your account has been paid in full, unless you have been referred for a consultation. We need 48 hours notice to enable us to mail X-rays in time for your appointment.

Appointment/Treatment
Pearson Chiropractic is a very busy clinic and when an appointment is scheduled for you we reserve that time for you only. There will not be a fee for rescheduling or canceling an Adjustment. ***However, for Massage Therapy, there is a $100 fee, for Rehab there is a $50 fee and for Acupuncture there is a $100 fee, if an appointment is not cancelled more than 24 hours in advance. A credit card must be on file for ALL PATIENTS, no exceptions. The credit card will be on file and charged automatically if there is a no-show or cancellation less than 24 hours in advance.***

Release and Wellness
If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

I have read and understand Pearson Chiropractic's office policies and I will honor them.

Patient's Printed Name: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

Credit card on file with us:

Card# _____ Exp Date: _____

Name as it Appears on Card: _____

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ACUPUNCTURE INTAKE

Patient Name _____ Date of Birth _____ Today's Date _____

Preferred Name _____ Pronouns _____

Have you been treated by Acupuncture or Chinese Medicine before? ☐ Yes ☐ No

Main Problem(s) you would like help with: _____

How long ago did this problem begin? (be specific) _____

To what extent does this problem interfere with your daily activities such as work or sleep? _____

Have you been given a diagnosis for this problem? ☐ Yes ☐ No

If so, what was the diagnosis? _____

What kinds of treatment have you tried? _____

Personal Medical History

Have you ever been diagnosed with any of the following? (please check the box and include date)

☐ Cancer	_____	☐ High Blood Pressure	_____	☐ Sexually Transmitted Disease	_____
☐ Diabetes	_____	☐ Heart Disease	_____	☐ HIV/AIDS	_____
☐ Hepatitis	_____	☐ Rheumatic Fever	_____	☐ Other	_____
☐ Seizures	_____	☐ Thyroid Disease	_____	☐ Other	_____

Surgeries (list type and date) _____

Significant Trauma (auto accidents, fall, etc. list type and date) _____

Allergies (list type such as drugs, chemicals or food and result) _____

List the medicines you have taken within the last two months (vitamins, drugs, herbs, etc) _____

List any Occupational Stress (physical, chemical, psychological, etc.) _____

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Do you have a **regular exercise program**? ☐ Yes ☐ No

Please describe: _____

Have you ever been on a **restricted diet**? ☐ Yes ☐ No

What kind? _____

PREGNANCY AND GYNECOLOGICAL HISTORY

Number of pregnancies _____
Number of births _____
Premature births _____
Miscarriages _____

Age at first menses _____
Days between menses _____
Duration of menses _____
First day of last menses _____

Do you practice birth control? ☐ Yes ☐ No
What form of birth control? _____
For how long? _____
Date of last pap smear _____

Family Medical History

Did your mother or father have any of the following: Put an **M** for mother, **F** for father, and **B** for both.

_____ Diabetes _____ High Blood Pressure _____ Stroke _____ Asthma
_____ Cancer _____ Heart Disease _____ Seizures _____ Allergies
_____ Other _____

Please check all of the following that you have had in the last 3 months:

GENERAL

☐ Poor appetite
☐ Fevers
☐ Sweat easily
☐ Localized weakness
☐ Bruise or bleed easily
☐ Peculiar tastes or smells
☐ Strong thirst (cold or hot)
☐ No desire to drink
☐ Sudden energy drop
What time of day?
_____
☐ Poor sleep
☐ Chills
☐ Tremors
☐ Poor balance
☐ Fatigue
☐ Night sweats
☐ Cravings
☐ Change in appetite
☐ Weight gain
☐ Weight Loss

SKIN AND HAIR

☐ Rashes
☐ Itching
☐ Dandruff
☐ Change in hair or skin
☐ Ulcerations
☐ Eczema
☐ Loss of hair
☐ Hives
☐ Pimples
☐ Recent moles
☐ Other hair or skin problems
_____

HEAD, EYES, EARS, NOSE, THROAT

☐ Dizziness
☐ Glasses
☐ Poor vision
☐ Cataracts
☐ Ringing in the ears
☐ Sinus problems
☐ Grinding teeth
☐ Teeth problems
☐ Concussions
☐ Eye strain
☐ Night blindness
☐ Blurry vision
☐ Poor hearing
☐ Nose bleeds
☐ Facial pain
☐ Jaw clicks
☐ Migraines
☐ Eye pain
☐ Color blindness
☐ Earaches
☐ Spots in front of eyes
☐ Recurrent sore throats
☐ Sores on lips on tongue
☐ Headaches: where and when?
_____
_____
☐ Other head or neck problems
_____
_____

CARDIOVASCULAR

- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Cold hands or feet
- ☐ Blood clots
- ☐ Low blood pressure
- ☐ Dizziness
- ☐ Swelling of hands
- ☐ Phlebitis
- ☐ Chest pain
- ☐ Fainting
- ☐ Swelling of feet
- ☐ Difficulty breathing
- ☐ Other heart or blood vessel problems

_____

_____

RESPIRATORY

- ☐ Cough
- ☐ Bronchitis
- ☐ Difficulty breathing
- ☐ Difficulty breathing when lying down
- ☐ Production of phlegm

  What color?_____
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Asthma
- ☐ Pain with deep breath
- ☐ Other lung problems

_____

_____

PREGNANCY AND GYNECOLOGY

- ☐ Unusually heavy or light periods
- ☐ Painful periods
- ☐ Irregular periods
- ☐ Vaginal discharge
- ☐ Changes in body/psyche prior to menstruation
- ☐ Clots
- ☐ Vaginal sores
- ☐ Breast lumps
- ☐ Pregnant or trying

GASTROINTESTINAL

- ☐ Nausea
- ☐ Constipation
- ☐ Black stools
- ☐ Bad breath
- ☐ Abdominal pain or cramps
- ☐ Chronic laxative use
- ☐ Vomiting
- ☐ Gas
- ☐ Blood in stools
- ☐ Rectal Pain
- ☐ Diarrhea
- ☐ Belching
- ☐ Indigestion
- ☐ Hemorrhoids
- ☐ Other stomach or intestinal problems

_____

_____

GENITO-URINARY

- ☐ Pain on urination
- ☐ Urgency to urinate
- ☐ Frequent urination
- ☐ Unable to hold urine
- ☐ Impotency
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Sores on genitals
- ☐ Waking up to urinate

How often?_____

Any particular color to your urine?

_____

- ☐ Other genital or urinary system problems

_____

_____

MUSCULOSKELETAL

- ☐ Neck pain
- ☐ Back pain
- ☐ Hand/wrist pain
- ☐ Muscle pain
- ☐ Muscle weakness
- ☐ Shoulder pain
- ☐ Knee pain
- ☐ Foot/ankle pain
- ☐ Hip pain

NEUROPSYCHOLOGICAL

- ☐ Seizures
- ☐ Areas of numbness
- ☐ Concussion
- ☐ Bad temper
- ☐ Dizziness
- ☐ Lack of coordination
- ☐ Depression
- ☐ Easily susceptible to stress
- ☐ Loss of balance
- ☐ Poor memory
- ☐ Anxiety
- ☐ Other neurological or psychological problems

_____

_____

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ACUPUNCTURE PATIENT QUESTIONNAIRE & CONSENT

The law requires patients receiving acupuncture to give their informed consent prior to receiving treatment. Informed consent is for the patient to be advised of the credentials of the practitioner(s) and the scope of the practice of acupuncture in the State of Washington.

The practitioner, Christian Hunt, EAMP, graduated from the Seattle Institute of Oriental Medicine with a Master's Degree in Acupuncture and Oriental Medicine. She has received additional training in gynecology, internal medicine, trigger point therapy, herbal medicine and dermatology.

Acupuncture is the insertion of a thin needle into the surface of the body. A patient may feel a slight pricking sensation and/or electrical impulse near the needle. Patients usually report little or no pain during an acupuncture treatment. On occasion, there may be slight bruising where a needle was inserted. The duration of a treatment is usually 30 minutes to one hour. Although no outcome of treatment can be guaranteed, it is understood that every patient is unique and that each treatment is designed specifically for the conditions of the patient.

As stated by law, therapy acupuncturists in the State of Washington are allowed to use the methods listed below. This in no way means that all these methods will actually be used for your treatment. You will be advised before any one of these methods is to be applied, and you always have the right to decline.

1. Use of acupuncture needles to stimulate acupuncture points
2. Use of electrical, magnetic, or mechanical devices to stimulate acupuncture points
3. Moxibustion (direct or indirect application of heat on acupuncture points using herbal materials)
4. Tui Na (acupressure)
5. Cupping
6. Injection therapy
7. Gua Sha (dermal friction)
8. Infra-red light
9. Sono-puncture (ultrasound)
10. Laser puncture
11. Dietary advice based on traditional Chinese medical theory

Patients with the following conditions must inform the practitioner(s) prior to receiving acupuncture treatments. Please check the following that apply.

_____ Pregnancy _____ Hepatitis _____ Severe bleeding disorders

_____ Pacemaker _____ AIDS or HIV positive

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the above named practitioner(s), or other licensed practitioners who now or in the future treat me while employed by, working or associated with or serving as back-up for the practitioner(s) above, including those working at the clinic or office listed above.

I understand that methods of treatment may include, but are not limited to, acupuncture, injection therapy, moxibustion, cupping, electrical stimulation, Tui Na, herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect and risks may occur.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I have been informed that injection therapy involves putting a needle into various areas of the body and injecting procaine and other homeopathic remedies. Risks of injection therapies include but are not limited to: discomfort, severe pain, bruising, inflammation, injury, and numbness at the site of injections. Other risks include fatigue, dizziness, light headedness, fainting or loss of consciousness during or after the procedure Rarely experienced reactions include severe allergic reaction, anaphylaxis, infection, cardiac arrest and death.

I have informed Christian Hunt of any known allergies to drugs or other substances, or any past reactions to anesthetics. I have informed Christian Hunt of all current medications, supplements, and medical conditions.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise their judgment for my best interests during the course of treatment, based upon the facts known at the time.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I, the undersigned, have read and understood the foregoing information and voluntarily consent to the use of the above procedures for treatments. I understand that there is no guarantee implied or expressed regarding the success or effectiveness of a treatment or a series of treatments. I hereby release Christian Hunt, EAMP, and the assistant(s) under her supervision, from all liability in connection with these treatments. I understand that I am free to withdraw my consent and stop treatment at any time.

Payment Policy:

I understand that regardless of my insurance status, I am ultimately responsible for any charges for professional services rendered by Christian Hunt, EAMP. I understand that Christian Hunt, EAMP, does not submit insurance claims; however, the staff of the clinic can assist me in my submission claims.

Cancellation Policy:

I understand that Christian Hunt, EAMP, reserves the right to charge for appointments canceled, rescheduled or missed without 24 hours advance notice.

Patient Name (PLEASE PRINT) Date

Patient Signature (if patient is over 18)

Patient Representative, Guardian PRINT NAME (if patient is under age 18) Relationship to Patient

Patient Representative, Guardian Signature (if patient is under age 18)

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ACUPUNCTURE PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any disputes to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resorting to a court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty (30) days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty (30) days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties' consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based on the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statue of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here _____. Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient Name (PLEASE PRINT) Date

Patient Signature (if patient is over 18)

Patient Representative, Guardian PRINT NAME (if patient is under age 18) Relationship to Patient

Patient Representative, Guardian Signature (if patient is under age 18)

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