



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 _____

Email 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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253.638.2424
15610 SE 272nd Street
Suite A-106
Covington, WA 98042

FEDERAL WAY
253.838.1441
1426 S 324th Street
Suite B115
Federal Way, WA 98003

AUBURN
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7084 Lakeland Hills Wy, SE
Suite 107
Auburn, WA 98092

MAPLE VALLEY
425.432.4621
27203 216th Ave, SE
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SPANAWAY
253.539.0132
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Suite A
Spanaway, WA 98387



**SCAN FOR
MORE INFO
ABOUT US!**

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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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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System Review (Have you had any problems with or treatment of any of the following? If yes, please describe.)

ALL PATIENTS	
Do you get dizzy when you turn your head and look back? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Thyroid <input type="checkbox"/> Yes <input type="checkbox"/> No	
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	
Head/Brain <input type="checkbox"/> Yes <input type="checkbox"/> No	
Eyes/Ears/Nose/Throat <input type="checkbox"/> Yes <input type="checkbox"/> No	
Lungs <input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart/Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	
Stomach/Bowel <input type="checkbox"/> Yes <input type="checkbox"/> No	
Bladder/Kidney <input type="checkbox"/> Yes <input type="checkbox"/> No	
Prostate <input type="checkbox"/> Yes <input type="checkbox"/> No	
Skin <input type="checkbox"/> Yes <input type="checkbox"/> No	
Nerves <input type="checkbox"/> Yes <input type="checkbox"/> No	
Medications <input type="checkbox"/> Yes <input type="checkbox"/> No	
Psychiatric <input type="checkbox"/> Yes <input type="checkbox"/> No	
Blood/Lymph/Immune System <input type="checkbox"/> Yes <input type="checkbox"/> No	

FEMALE PATIENTS ONLY	
Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last menses: _____
Are you taking birth control pills or shots? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Thickening of the breast or breast pain? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Vaginal bleeding or discharge? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Past Medical History (Have you had any of any of the following? If yes, please describe.)

Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	
On the job injuries <input type="checkbox"/> Yes <input type="checkbox"/> No	When? _____ Which body part? _____
Motor vehicle accident <input type="checkbox"/> Yes <input type="checkbox"/> No	When? _____
Other injuries <input type="checkbox"/> Yes <input type="checkbox"/> No	
Illnesses <input type="checkbox"/> Yes <input type="checkbox"/> No	
Hospitalizations <input type="checkbox"/> Yes <input type="checkbox"/> No	
Surgeries <input type="checkbox"/> Yes <input type="checkbox"/> No	
Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No	
Implants or Joint Replacements <input type="checkbox"/> Breast <input type="checkbox"/> Knee <input type="checkbox"/> Hip <input type="checkbox"/> Other (specify) _____	

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Family History (Did your mother or father have any of the following? Put an **M** for mother, **F** for father, **B** for both)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Ulcer or Stomach Problems | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Circulation Problems |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Arthritis-Rheumatism | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> HIV Positive | | | |

Social History

What level of education have you completed? Elementary Jr. High High School College (2 year) College (4 year)

Have you served in the military? Yes No Where? _____

What is your occupation? _____ Are you retired? Yes No

Do you use tobacco? Yes No How much per week? _____

Do you use alcohol? Yes No How much per week? _____

What are your hobbies? _____

Other Medical Information

- | | |
|--|--|
| Do you have chest pain? <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you noticed changes in your memory? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have a sore on your skin that does not heal? <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have any ringing in your ears? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have a nagging cough or hoarseness? <input type="checkbox"/> Yes <input type="checkbox"/> No | Does your pain ever wake you from a sound sleep? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have night sweats? <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you losing weight now without trying? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have pain in or numbness your jaw or face? <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you coughing up blood or noticing it in your stools or urine? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have a drooping eyelid or and change in your pupils? <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you lost consciousness recently? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have any nausea or vomiting? <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you seeing any other doctor for any other reason? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have any slurred speech? <input type="checkbox"/> Yes <input type="checkbox"/> No | Note: _____ |
| Have you noticed changes in your balance? <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Comments

I certify that the information I give is correct to the best of my knowledge. I will not hold the doctors or staff responsible for any errors or omissions that I may have made and I authorize this office to provide chiropractic care.

Print Patient Name _____ Date _____

Patient Signature _____

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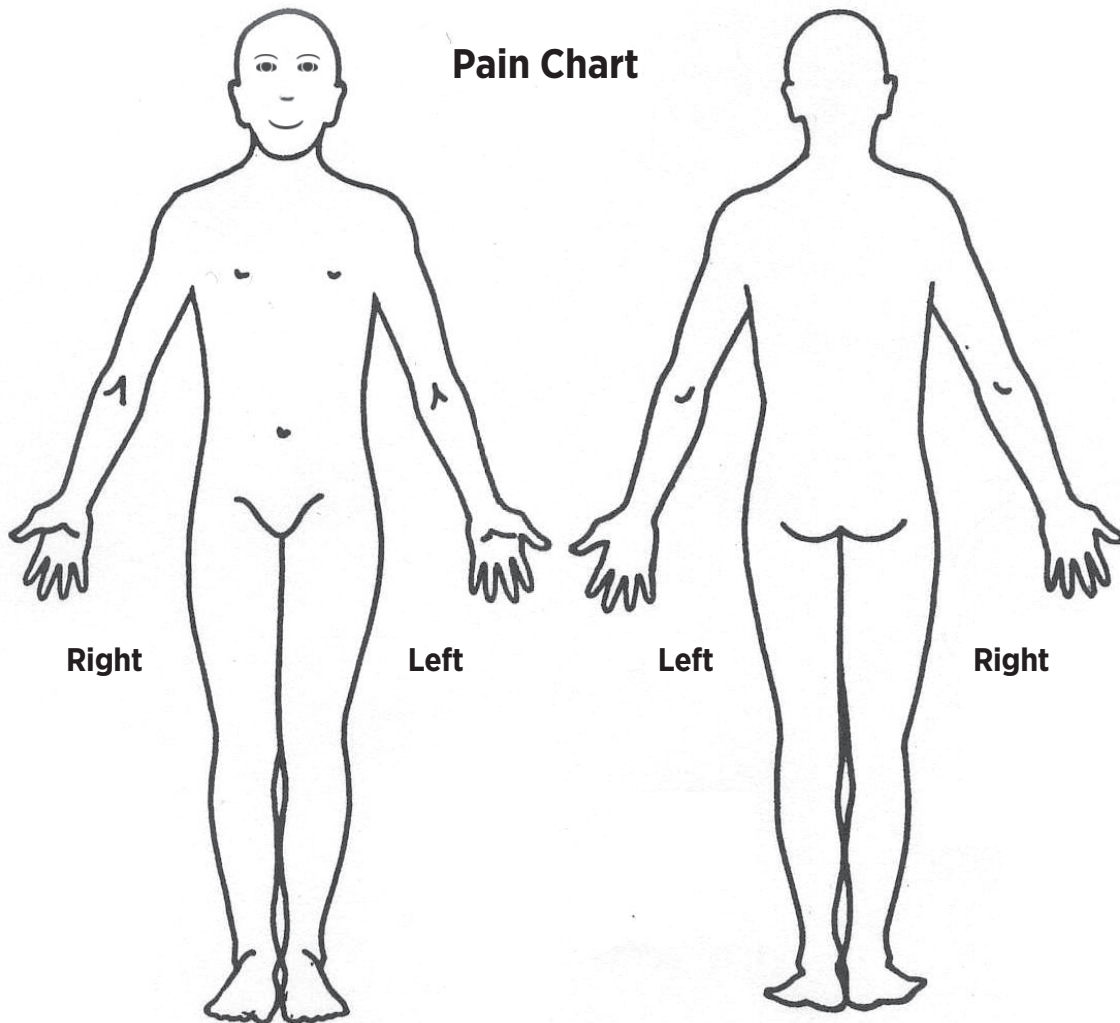
Date _____

Name _____

WHEN did the pain start? _____

HOW did the pain start? _____

On the body diagrams below, please circle all areas in which you have pain. Then place a number for your level of pain inside the circle. **1** is good and **10** is your worst pain ever.



_____ Date

_____ Signature



Patient Name

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As a part of the analysis, examination and treatment, you are consenting to the following procedures:

- | | |
|-----------------------------|----------------------------|
| Spinal manipulative therapy | Postural analysis |
| Range of motion testing | Hot/cold therapy |
| Muscle strength testing | Vital signs |
| Radiographic studies | Palpation |
| Basic neurological testing | Myofascial Release Therapy |
| Orthopedic testing | Mechanical Traction |

The material risks inherent in chiropractic adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatories, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this growth may complicate treatment making it more difficult and less effective the longer it is postponed.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BOX AND SIGN BELOW.**

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with _____ and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Date

Date

Patient's Name (Printed)

Doctor's Name (Printed)

Patient's Signature

Doctor's Signature

Signature of Parent or Guardian (if a minor)

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