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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Covington, WA 98042

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MAPLE VALLEY
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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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MASSAGE INTAKE

Patient Name _____ Phone No. _____ Date of Birth _____

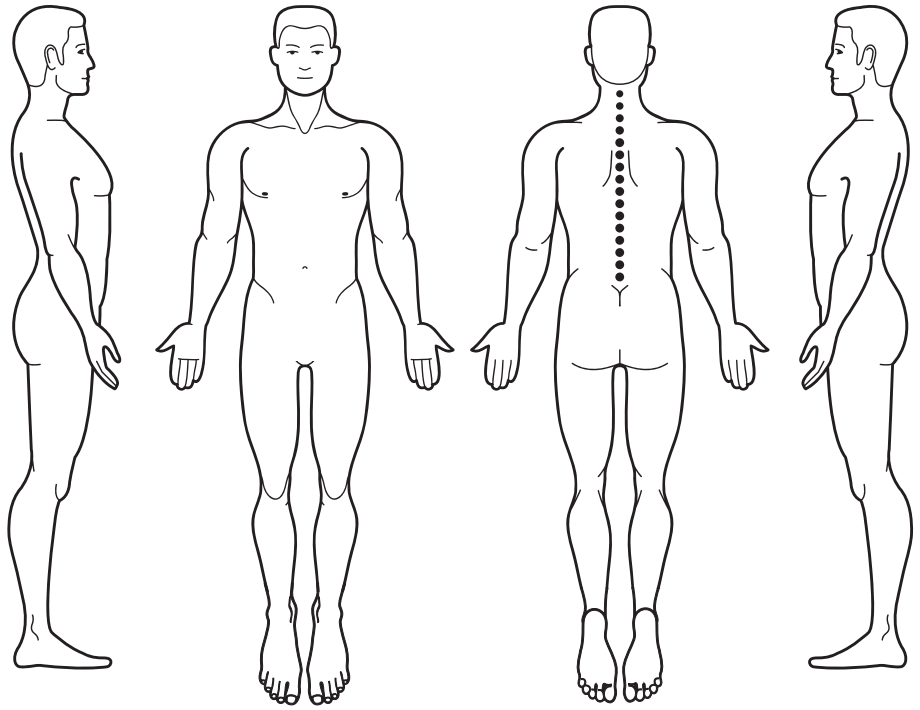
Doctor _____ Today's Date _____

The following information will be used to help plan safe and effective massage sessions.
Please answer all questions to the best of your knowledge.

Have you had a professional massage before? ☐ Yes ☐ No	If yes, how often do you receive massage therapy?
Do you have trouble laying on your stomach, back or side? ☐ Yes ☐ No	
Do you have any allergies to oils, lotions, or ointments? ☐ Yes ☐ No	If yes, please explain:
When did your pain start? Date:	If unsure please explain:
What caused your pain?	If unsure please explain:
What activities aggravate your pain?	Please explain:
Do you experience stress in your work, family, or other aspect of your life? ☐ Yes ☐ No	If yes, how do you think it has affected your health? ☐ muscle tension ☐ anxiety ☐ insomnia ☐ irritability ☐ other _____ Please explain:

Mark the specific areas where you have pain on the figure to the right.

Mark each place with a pain level of 1-10 to indicate mild (1) to extreme pain (10).



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Are you currently under medical supervision? ☐ Yes ☐ No

If yes, please explain: _____

Are you currently taking any medication? ☐ Yes ☐ No

If yes, please explain: _____

Please check any condition listed below that applies to you

- ☐ contagious skin condition
- ☐ phlebitis
- ☐ open sores or wounds
- ☐ deep vein thrombosis/ blood clots
- ☐ easy bruising
- ☐ joint disorder/ arthritis/ tendonitis
- ☐ recent accident or injury
- ☐ osteoporosis
- ☐ recent fracture
- ☐ epilepsy
- ☐ recent surgery
- ☐ headaches/ migraines
- ☐ artificial joint
- ☐ cancer
- ☐ sprains/ strains
- ☐ diabetes
- ☐ current fever
- ☐ back/ neck problems
- ☐ swollen glands
- ☐ fibromyalgia
- ☐ allergies/ sensitivity
- ☐ TMJ
- ☐ heart condition
- ☐ HIV/AIDS
- ☐ carpal tunnel syndrome
- ☐ high or low blood pressure
- ☐ tennis elbow
- ☐ circulatory disorder
- ☐ atherosclerosis
- ☐ varicose veins
- ☐ pregnancy
  If yes, how many months? _____

Please explain any condition that you have marked above:

_____

_____

_____

Please explain anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you.

_____

_____

_____

FOR ALL MASSAGE PATIENTS, NO EXCEPTIONS

ALL APPOINTMENTS MUST BE CANCELLED 24 HOURS PRIOR TO THE APPOINTMENT TIME. FAILURE TO KEEP APPOINTMENTS WITH OUT A 24 HOUR NOTIFICATION WILL RESULT IN A $85 FEE BILLED TO YOU AND NOT TO YOUR INSURANCE. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY BILLS INCURRED.

I understand that massage therapists do not diagnose illness, disease, or other physical or mental disorders. Massage therapists do not prescribe medical treatment or pharmaceuticals. It has been made clear to me that massage is not a substitute for medical examination or diagnosis and that it is recommended that I see a physician for any physical ailment that I may have. I have stated all my known medical conditions and I am personally responsible for keeping the massage therapist updated on my physical health.

Print Patient Name _____ Date _____

Patient Signature _____

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