KEVIN EARLE, D.C., DACBSP, C.S.C.S.
VANKOSIN (KRYS) HEWITT L.M.P.
SYBIL BURNHAM, L.M.P.

13613 Meridian East, Suite 260
Puyallup, Washington 98373
Office (253) 445-0440
Fax (253) 445-0444
RainierSportsRehab.com

Patient Information

Name: _____ Date: _____
First Middle Initial Last

Address: _____ City: _____ State: _____ Zip: _____

Sex: Female Male Birth Date: _____ Email: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Do you prefer to receive calls at: Home Work Cell No Preference

Are you? Married Widowed Single Minor Separated Divorced Partnered

Patient Employer/School Address: _____ Occupation: _____

Spouse or parent's name: _____ Employer: _____ Work Phone: _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency: _____ Phone Number: _____

Insurance Information (Medical)

Name of Insured _____ Relationship to Patient _____

Birth Date _____ Name of Employer _____

Occupation _____ Work Phone _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Phone _____ Group # _____ Identification # _____

DO YOU HAVE ADDITIONAL INSURANCE? No Yes IF YES PLEASE COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birth Date _____ Name of Employer _____

Occupation _____ Work Phone _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Phone _____ Group # _____ Identification # _____

(Auto / Labor and Industries)

Company Name _____ Date of Loss _____

Claim Adjuster's Name _____ Claim Number _____

Claim Adjuster's Phone _____ Ext _____

Address _____ City _____ State _____ Zip _____

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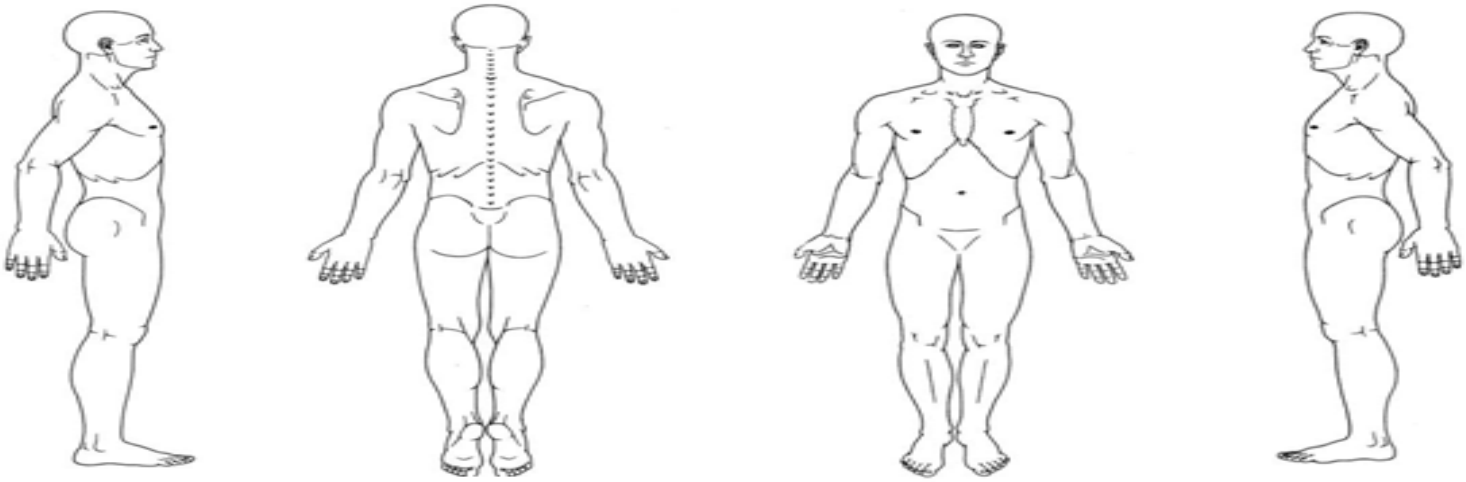
PATIENT HISTORY FORM

1. Is today's problem caused by: ☐ Auto Accident ☐ Workman's Compensation ☐ Other
2. Indicate on the drawings below where you have pain/symptoms:



3. How often do you experience your symptoms?
   ☐ Constantly (76-100% of the time) ☐ Occasionally (26-50% of the time)
   ☐ Frequently (51-75% of the time) ☐ Intermittently

4. How would you describe the type of pain/symptoms? (check all that apply)
   ☐ Sharp ☐ Dull ☐ Stiff ☐ Electric like with Motion
   ☐ Diffuse (pain travels) ☐ Tingly ☐ Shooting ☐ Sharp with Motion
   ☐ Achy ☐ Burning ☐ Numb ☐ Shooting with Motion
   ☐ Other: _____ ☐ Other: _____ ☐ Stabbing with Motion

5. How are your symptoms changing with time?
   ☐ Getting Worse ☐ Staying the Same ☐ Getting Better

6. Using a scale from 0-10 (10 being worst), how would you rate your pain intensity?
   Past 24 hours: 0 1 2 3 4 5 6 7 8 9 10 (circle one)
   Past Week: 0 1 2 3 4 5 6 7 8 9 10 (circle one)

7. How much has the problem interfered with your work?
   ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

8. How much as the problem interfered with your usual daily activities?
   ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

9. Who else have you seen for this problem?
   ☐ Chiropractor ☐ Neurologist ☐ ER Physician ☐ Orthopedist
   ☐ Physical Therapist ☐ Massage Therapist ☐ No One ☐ Other:_____

10. How long have you had this problem? _____
11. How do you think your problem began? _____
12. Do you consider this problem to be severe?
    ☐ Yes ☐ Yes, at times ☐ No
13. What aggravates your problem? _____
14. What concerns you the most about your problem; what does it prevent you from doing?
    _____

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Daily Habits

1. How do you rate your overall health?
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
2. Do you exercise on a daily basis?
   ☐ Not at all ☐ Light ☐ Moderate ☐ Strenuous
3. What type of exercise/activities do you do outside of work?
   _____
4. Do you smoke? Yes No How much per day? _____
5. Do you consume liquor? Yes No How much a day/ How often? _____ / _____
6. Do you consume coffee or caffeinated drinks? Yes No How much a day? _____

Work Habits

1. Your daily work Habits include?

☐ Sitting:	☐ Most of the Day	☐ Half the Day	☐ 2-4 hours of the Day
☐ Standing:	☐ Most of the Day	☐ Half the Day	☐ 2-4 hours of the Day
☐ Computer Work:	☐ Most of the Day	☐ Half the Day	☐ 2-4 hours of the Day
☐ On the Phone:	☐ Most of the Day	☐ Half the Day	☐ 2-4 hours of the Day

Medical History

1. Height _____ Weight _____
2. List all prescription medications you are currently taking: _____
   _____
3. List all of the over the counter medications/ vitamins/ nutritional supplements you are currently taking:
   _____
4. Have you ever been hospitalized? Yes No
   Explain: _____
5. Have you had significant past trauma? Yes No
   Explain: _____
6. Indicate if you have any immediate family members with any of the following:
   ☐ Rheumatoid Arthritis ☐ Diabetes ☐ Lupus
   ☐ Heart Problems ☐ Cancer ☐ ALS
7. For each of the following conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	
☐	☐	Headaches
☐	☐	Neck Pain
☐	☐	Upper Back Pain
☐	☐	Mid Back Pain
☐	☐	Low Back Pain
☐	☐	Shoulder Pain
☐	☐	Elbow/Upper Arm Pain
☐	☐	Wrist Pain
☐	☐	Hand Pain
☐	☐	Hip Pain
☐	☐	Upper Leg Pain
☐	☐	Knee Pain
☐	☐	Ankle/Foot Pain
☐	☐	Jaw Pain
☐	☐	Joint Pain/Stiffness
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	Cancer
☐	☐	Tumor
☐	☐	Other

Past	Present	
☐	☐	High Blood Pressure
☐	☐	Heart Attack
☐	☐	Chest Pains
☐	☐	Stroke
☐	☐	Angina
☐	☐	Kidney Stones
☐	☐	Kidney Disorders
☐	☐	Bladder Infection
☐	☐	Painful Urination
☐	☐	Loss of Bladder Control
☐	☐	Prostate Problems
☐	☐	Abnormal Weight Gain/Loss
☐	☐	Loss of Appetite
☐	☐	Abdominal Pain
☐	☐	Ulcer
☐	☐	Hepatitis
☐	☐	Liver/Gall Bladder Disorder
☐	☐	General Fatigue
☐	☐	Muscular Incoordination

Past	Present	
☐	☐	Diabetes
☐	☐	Excessive Thirst
☐	☐	Frequent Urination
☐	☐	Smoking/Tobacco Use
☐	☐	Drug/Alcohol Dependance
☐	☐	Allergies
☐	☐	Asthma
☐	☐	Chronic Sinusitis
☐	☐	Depression
☐	☐	Systemic Lupus
☐	☐	Epilepy
☐	☐	Dermatitis/Eczema/Rash
☐	☐	HIV/AIDS
☐	☐	Visual Disturbances
☐	☐	Dizziness
		For Females Only
☐	☐	Birth Control Pills
☐	☐	Hormonal Replacement
☐	☐	Pregnancy

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New Patient Intake Form

Informed Consent to Chiropractic and Therapeutic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other therapeutic procedures including various modes of rehab, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible: _____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by **Rainier Sports & Spinal Rehab** and /or other licensed chiropractic physicians who may treat me now or in the future at this clinic. I have had an opportunity to discuss with **Dr. Kevin Earle** and /or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all health care, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its consent, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and/or for any condition(s) for which I seek treatment at this facility.

_____

Print Patient's Name

_____

Signature of Patient or Parent, Guardian or Personal Representative

_____

Relationship to Patient Date

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FINANCIAL AGREEMENT

We are committed to providing you with the best possible care. If you have medical insurance, we are willing to help you receive your maximum allowable benefits. In order to do this, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time of your visit, unless payment arrangements have been made, in advance, with our staff. We accept Cash, Checks, MasterCard or Visa.

Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1% per month. Account balances over 120 days may be sent to an agency.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. We will be happy to process your insurance claim. You must realize, however, that:

8. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
9. Our fees are generally considered to fall within acceptable range by most companies and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies that pay a percentage (such as 50% or 80% of U.C.R.) U.C.R. is defined as Usual, Customary & Reasonable fess for this region.
10. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services that they will not cover.

We must emphasize that our relationship is with you and not your insurance company. While filing of insurance and/or submitting documentation to 3rd parties for payment is a courtesy that we extend to our patients, all charges are ultimately your responsibility from the date the services are rendered.

We realize that temporary financial problems my affect timely payment of your account. If such problems do arise, we require that you contact us promptly for assistance in the management of your account.

I authorize and request my insurance company, or liable party, to make payment directly to **Rainier Sports and Spinal Rehab**, benefits otherwise payable to me. If my insurer issues partial payment, denies my claim, or for any other reason fails to pay my claim within 45 days of treatment, I agree to pay the balance of my account in full. _____ (initial)

I hereby give permission to **Rainier Sports and Spinal Rehab** to discuss my treatment with any of my medical providers, and/or my attorney(s) of record. _____ (initial)

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

_____
Print Patient's Name

_____
Signature of Patient or Parent, Guardian or Personal Representative

_____
Relationship to Patient Date

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare Providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-pat payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____
Print Patient's Name

_____
Signature of Patient or Parent, Guardian or Personal Representative

_____
Relationship to Patient Date

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

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Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Rainier Sports and Spinal Rehab all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named clinic may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year for the date signed below.

_____

Print Patient's Name

_____

Signature of Patient or Parent, Guardian or Personal Representative

_____

Print Name of Parent, Guardian or Personal Representative

_____

Relationship to Patient Date

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Notice of Privacy Practices

THIS INFORMATION DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you the notice about your privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect on 4/13/2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For Example:

Treatment: We may use and disclose your health information to a physician or other healthcare provider providing treatment for you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Tour Authorization: In addition to our use of your healthcare information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as directed in the Patient Rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use and disclose your health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health Related Services; We will not use your health information for marketing communications without your written authorization.

Required By Law: We may use or disclose your health information when we are required to do so by law.