Roosevelt Chiropractic
5029 Roosevelt Way NE Ste 101A, Seattle WA 98105
206-547-4427

Confidential History Form

Date: _____

Name: _____ Preferred Name: _____ Date of Birth: _____

Address: _____ City/State: _____ Zip Code: _____

Home #: _____ Cell #: _____ Cell Carrier: _____ (If you prefer text message reminders)

Social Security #: _____ Marital Status: S / M / W / D / Domestic Partner Spouse's Name: _____

Employer: _____ Occupation: _____

Work Address: _____ Email: _____

Work #: _____ Fax #: _____ Height: _____ Weight: _____

Emergency Contact: _____ Phone #: _____ Referred By: _____

Area Of Pain	How Long Have You Had It?	What Makes It Worse?	What Makes It Better?
1.			
2.			
3.			

Are your problems the result of a work related accident or automobile collision? YES NO
If YES, please advise staff ***immediately***.
Please list the two most recent doctors you have seen, the date of service and the reason consulted:

1. _____
2. _____

Please list any medications you are now taking & why: _____

_____

List any surgeries or fractures with the date of occurrence: _____

Have you ever been to a chiropractor? YES NO If yes, Who: _____ When: _____

Do you have or have you experienced any pain in the following areas?
If yes, what is the date of occurrence?

- ☐ Neck: _____
- ☐ Shoulder: _____
- ☐ Arm: _____
- ☐ Elbow: _____
- ☐ Wrist: _____
- ☐ Hand: _____
- ☐ Upper Back: _____
- ☐ Chest: _____
- ☐ Middle Back: _____
- ☐ Low Back: _____
- ☐ Hip: _____
- ☐ Pelvic: _____
- ☐ Leg: _____
- ☐ Knee: _____
- ☐ Ankle: _____
- ☐ Foot: _____
- ☐ Other: _____

Do experience increased pain at night?
YES NO What area(s)?: _____

_____

Do you have or have you ever had any of the following conditions? If yes, please check the box and provide dates of occurrence.

- ☐ Addison's: _____
- ☐ Alcoholism: _____
- ☐ Asthma: _____
- ☐ Arthritis: _____
- ☐ Bipolar: _____
- ☐ Cancer: _____
  Type: _____
- ☐ Dizziness: _____
- ☐ Epilepsy: _____
- ☐ Fainting: _____
- ☐ Fibromyalgia: _____
- ☐ Genital Discharge: _____
- ☐ Headaches: _____
- ☐ Hepatitis: _____
  Type: _____
- ☐ Herpes: _____
- ☐ HIV/AIDS: _____
- ☐ Impaired Vision: _____
- ☐ Insomnia: _____
- ☐ Kidney Infection: _____
- ☐ Kidney Stones: _____
- ☐ Loss of Bladder Control: _____
- ☐ Numbness: _____
  Where: _____
- ☐ Painful Urination: _____
- ☐ Prostatitis: _____
- ☐ Ringing in Ears: _____
- ☐ Shortness of Breath: _____
- ☐ Stomach Ulcer: _____
- ☐ Stroke: _____
- ☐ Tuberculosis: _____
- ☐ Other: _____

Roosevelt CHIROPRACTIC

Mark S. Jyringi, DC, PS | Jeremiah Tibbitts, DC | Brian Stuck, DC
5029 Roosevelt Way NE, Suite 101A Seattle, WA 98105 Phone: 206.547.4427

Today's Major Complaints	***Please Circle***	***0- No Pain***										***10=Extreme Pain***
☐ Headache		0	1	2	3	4	5	6	7	8	9	10
☐ Neck Pain	☐ Left ☐ Right	0	1	2	3	4	5	6	7	8	9	10
☐ Shoulder Pain	☐ Left ☐ Right	0	1	2	3	4	5	6	7	8	9	10
☐ Arm Pain	☐ Left ☐ Right	0	1	2	3	4	5	6	7	8	9	10
☐ Mid Back Pain		0	1	2	3	4	5	6	7	8	9	10
☐ Low Back Pain		0	1	2	3	4	5	6	7	8	9	10
☐ Hip Pain	☐ Left ☐ Right	0	1	2	3	4	5	6	7	8	9	10
☐ Leg Pain	☐ Left ☐ Right	0	1	2	3	4	5	6	7	8	9	10
☐ Other _____		0	1	2	3	4	5	6	7	8	9	10

I feel more pain when doing the following activities:				***Check & Circle those that apply***
☐ Sleeping	Minimal	Mild	Moderate	Severe
☐ Sitting	Minimal	Mild	Moderate	Severe
☐ Walking	Minimal	Mild	Moderate	Severe
☐ Standing	Minimal	Mild	Moderate	Severe
☐ Lifting	Minimal	Mild	Moderate	Severe
☐ Household Chores	Minimal	Mild	Moderate	Severe
☐ Routine Personal Care	Minimal	Mild	Moderate	Severe
☐ Other _____	Minimal	Mild	Moderate	Severe

Is this a: ☐ Old, Chronic Problem ☐ New Condition

What happened to worsen or cause this condition?

☐ Fall in the house or outside
☐ Housework (vacuuming, cooking, washing dishes, etc)
☐ Lifting (mattress, garbage, groceries, etc.)
☐ Traveling (long drive or plane flight)
☐ Other _____
☐ Car Accident
☐ Other accident
☐ Yard Work
☐ Not sure what made me worse

When did this happen or worsen: ☐ Today ☐ Other Date: _____

Do chiropractic adjustments give you relief and/or improve your ability to function? YES NO Usually

"I understand that Medicare will only cover treatment related to an acute (new) condition or a flare-up of a chronic condition and will not pay for routine check-ups/ maintenance care. I have also been informed by my chiropractor that he cannot predetermine if Medicare will pay for my spinal adjustments on any given office visit. If Medicare denies payment for any office visit, I agree to be responsible for the payment."

Signature: _____ ***Date:*** _____

Print Name: _____

DIAGNOSIS- FOR DOCTORS' USE ONLY

☐ **CERVICAL M99.01**
- ☐ Cervicalgia M54.2
- ☐ Strain S13.4XXA ☐ Sprain S16.1XXA
- ☐ IVD degeneration M50.30

☐ **THORACIC M99.02**
- ☐ Pain in thoracic spine M54.6
- ☐ Sprain S23.3XXA
- ☐ IVD Degeneration M51.34

☐ **LUMBAR M99.03**
- ☐ Lumbago M54.5
- ☐ Sprain S33.5XXA ☐ Strain S39.012A
- ☐ Displacement of disc M51.26

☐ **SACRAL M99.04**
- ☐ Sacro-iliac Pain M53.87
- ☐ Sprain S33.6XXA
- ☐ IVD degeneration M51.36

☐ **PELVIC M99.05**
- ☐ Backache Unspecified M54.9
- ☐ Sprain S33.8XXA
- ☐ Sciatica M54.40

PLAN: _____ **DR.'S INITIALS:** _____

NOTICE OF MEDICARE COVERAGE FOR CHIROPRACTIC CARE

Your Medicare coverage of chiropractic care is limited. It does not pay for all services. It will only pay for your chiropractic adjustment (manipulative treatment) when it meets Medicare's specific rules. There are three categories of Medicare services: 1) non-covered 2) always-covered, and 3) perhaps-covered.

NON-COVERED SERVICES

According to existing Medicare law, most of the services in our office are NON-COVERED. Hopefully, the U.S. Congress will change that someday and treat Doctors of Chiropractic like all other doctors. Until then, here is a summary:

Examples of Non-Covered Services

All Services Other than Chiropractic Adjustments:

- Office Visits - to evaluate and manage, re-evaluate, advise, or give counsel regarding your health.
- Physiotherapy - such as massage, traction, electrical stimulation, neuromuscular re-education, etc.
- X-rays, Laboratory, Supplies, Vitamins, etc.

Various Chiropractic Adjustments or Treatments:

- Non-spinal manipulation to the shoulder, arm, leg, etc.
- Maintenance Care - you are stable and not making any more improvement.
- Wellness Care - to promote better health.

ALWAYS-COVERED SERVICES

A Medicare COVERED service is for when you are injured or when you are in pain due to a bad spinal condition. Medicare pays for your rehabilitation as long as you are improving. This phase of care is call "active treatment." It will be shown on your Medicare claim form and payment reports with your service code. For example, "98940-AT."

PERHAPS-COVERED SERVICES

Your Chiropractic Adjustment must be clinically needed to correct a problem of the spine, according to Medicare rules. If Medicare determines that your condition is not "Medically Necessary" they will not pay. When we know or believe that your chiropractic adjustment is no longer covered, we will discuss this matter with you. We will also give you a Medicare form known as the Advance Beneficiary Notice (ABN) which will show your financial obligation for continued care.

MY FINANCIAL RESPONSIBILITY

I have received the above Medicare information. I understand that I am personally **financially responsible** for all services not covered by Medicare. I am also responsible for applicable annual deductibles or copayments.

x _____ _____

Signature of patient or person acting on patient's behalf — Date

MY AUTHORIZATION

I authorize the **release** of any medical or other information necessary to process my claims. I also **request** payment of government or private benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

x _____ _____

Signature of patient or person acting on patient's behalf — Date

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to a payer, your health information on this form may be shared with the payer. Your health information which the payer sees will be kept confidential by the payer.

Mark S. Jyringi, DC, PS, DBA Roosevelt Chiropractic

5029 Roosevelt Way NE, Suite 101A, Seattle, WA 98105

Phone: 206.547.4427 I Fax: 206.547.3587

- A Little About Chiropractic -

Before beginning treatment, it is our office policy to inform you of what to expect, of possible complications of chiropractic care and of complications of other approaches. Remember that all forms of treatment (including non-treatment!) have associated risks. If you have any questions, please ask the doctor.

What to expect: The treatment at our office will consist of manipulation of the joints and soft tissues, using the hands and/or a mechanical instrument. You may feel joint movement and you may hear joint clicks or other noises. Physical therapy methods, along with therapeutic exercise, may also be used.

Chiropractic Risks: Chiropractic examination and therapy (adjustments, heat, electrotherapy, etc) are considered very safe and effective methods of care. Occasionally, however, complications can arise. Minor, temporary problems, such as soreness and stiffness can occur, especially in the beginning of a treatment plan. Slightly more serious problems are local burns from heat generating physical therapy equipment. More significant problems, such as fracture of weakened bone of sprain/disc injuries are rare. A stroke following neck manipulation is an extremely rare complication, occurring less than 1 per million treatments. Stroke has also been the result of ordinary activities, such as head turning or stargazing.

Other Treatment and Risks:

Medications: Many commonly used medications, such as NSAIDs (e.g. Advil, Aleve or Tylenol), carry risks of tissue damage, including stomach ulcers or kidney damage can occur quickly and may be irreversible. There is a significantly higher risk of developing a serious complication with NSAIDs as opposed to chiropractic treatment. Other medications are habit-forming and may mask pain to allow further tissue damage.

Surgery: Surgery is the treatment choice for less than 1% of back pain patients. Your doctor will screen for surgical "red flags," and will refer you for a surgical opinion if indicated. Clinical results of surgery for mechanical back pain have been disappointment and may expose you to unnecessary hospital and medication risks.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read the above and give my consent to begin chiropractic treatment.

Patient Name: _____ Date: _____

Signature: _____ Relationship to Patient: _____

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Consent for Purposes of Treatment, Payment and Health Care Operations

I authorize **Mark S. Jyringi, D.C., P.S., Jeremiah Tibbitts, D.C., and/or Brian Stuck, D.C.** to use and disclose the health and medical information of _____ for the purposes of Treatment, Payment and Health Care Operations*.

* **Treatment:** Includes activities performed by a health care provider, nurse, office staff and other types of health care professionals providing care to you, coordinating or managing your care with third parties and consultations with and between other healthcare providers. This consent includes treatment provided by any physician who covers my/our practice by telephone, as well as the on-call physician.

* **Payment:** Includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims and utilization management activities, which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.

* **Health Care Operations:** Includes the necessary administrative and business functions of our office.

We are committed to preserving the privacy of your personal health information. We are required by law to have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporti your treatment.

You may review **Mark S. Jyringi, D.C., P.S., Jeremiah Tibbitts, D.C., and/or Brian Stuck, D.C.** "Notice of Privacy Practices" for additional information about the uses and disclosures of information described in this Consent prior to signing this Consent.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. We will offer you a copy of the Notice on your first visit to us after the effective date of the then current Notice. We will also provide you with a detailed Notice of Privacy Practices upon your request which fully explains you rights and our obligations under the law.

As more fully explained in the notice you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment and health care operations purposes. We are not required to agree to your reque If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice. If you have any questions, concerns or complaints about the Notice or your medical information, please contact **Charmaine Strom** at our office at (206) 547-4427.

I understand that I have the right to revoke this consent provided that I do so in writing, except to the extent that **Mark S. Jyringi, D.C., P.S., Jeremiah Tibbitts, D.C., and/or Brian Stuck, D.C.** has already used or disclosed the information in reliance on this Consent.

Patient Printed Name: _____ Date: _____

Signature of Patient: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____