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: _____

Bournemouth Neck and Low Back Questionnaire

1. **Over the past week, on average how would you rate your Neck or Back pain?**
   (No pain) 0 1 2 3 4 5 6 7 8 9 10 **(Worst pain possible)**

2. **Over the past week, how much has your Neck or Back pain interfered with your daily activities such as: housework, washing, dressing, lifting, reading, and/or driving?**
   (No interference) 0 1 2 3 4 5 6 7 8 9 10 **(Unable to carry out activities because of pain)**
   Please Describe: _____

3. **Over the past week, how much has your Neck or Back pain interfered with your ability to take part in recreational, social, and/or family activities?**
   (No interference) 0 1 2 3 4 5 6 7 8 9 10 **(Unable to carry out activities)**
   Please Describe: _____

4. **Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling? (Not at all anxious)** 0 1 2 3 4 5 6 7 8 9 10 **(Extremely anxious)**

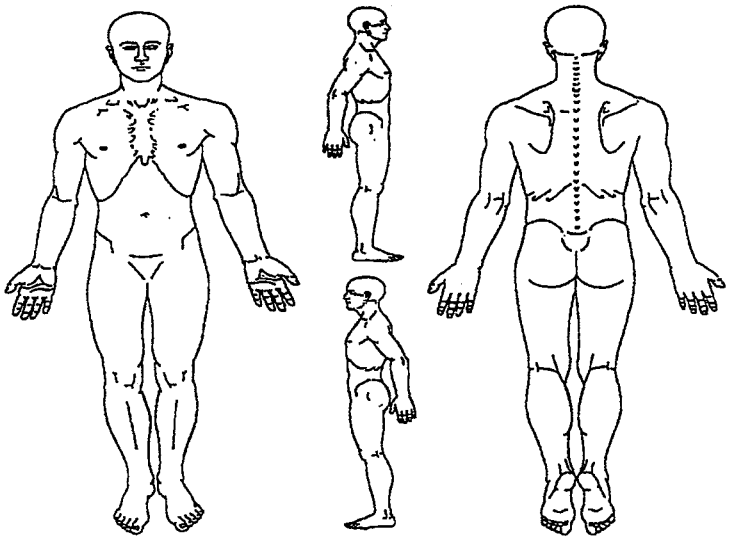
5. **Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, or unhappy) have you been feeling? (Not at all depressed)** 0 1 2 3 4 5 6 7 8 9 10 **(Extremely depressed)**

6. **Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your Neck or Back pain?**
   (Made it no worse) 0 1 2 3 4 5 6 7 8 9 10 **(Made it much worse)**
   If worse, which activities? _____

7. **Over the past week, how much have you been able to control (reduce/help) your Neck or Back pain on your own? (Completely control of it)** 0 1 2 3 4 5 6 7 8 9 10 **(No control whatsoever)**
   What have you done? _____

Please use the letters below to indicate the type and location of your sensations right now.
A= Ache B= Burning N= Numbness P= Pins and Needles S=Stabbing O= Other

Please review your condition. Let us know if you are having problems in the following areas.



Patient Signature: _____ **Date:** _____

FINANCIAL POLICY AND AGREEMENT

Roosevelt Chiropractic

I, the undersigned, in consideration of the Office's services, agree to the following terms:

Definitions. In this Agreement, "Office" and "Clinic" shall refer to **Mark S. Jyringi, DC, PS DBA Roosevelt Chiropractic**. "Financial Policy" or "Agreement" shall refer to this document.

Personal Responsibility for My Charges. I understand that I remain personally responsible for my Charges and that at any time, I can request a copy of my total Charges from the Office. Except where provided otherwise by law or by contract, I agree to pay the full amount of my Charges to the Office promptly upon its demand. I understand that the Office's Assignment does not constitute an agreement by the Office to await payment of my Charges. A monthly interest charge of 1% will be charged for bills that are greater than 30 days past due. Unless otherwise mutually agreed to in writing on a form provided by the Office, I agree that (1) any delay by the Office in making demand for payment, any delay in paying the full amount of my Charges, and any partial payments received by the Office towards my Charges, shall not constitute acceptance of any installment payment plan, shall not constitute a waiver of the Office's right to receive payment-in-full promptly upon demand, and shall not constitute an "accord and satisfaction" of my Charges, regardless of any such terms or restrictions indicated on, or included with, any payments, and (2) any delay in paying the full amount of my Charges beyond fourteen (14) calendar days of demand shall by construed as a "default" of my obligation.

Personal Responsibility for Verifying the Limitations in My Coverage; Financial Responsibility for Non-Covered Charges. I understand that in any given situation, a Payer may initially refuse to make payment to the Office, may delay payment for an indefinite or unreasonable amount of time, or may actually request a refund from the Office after making payment, and do so either in whole or in part with respect to any given Charge incurred at the Office (collectively, "Deny Payment"). For example (without limiting this Agreement), I understand that a Payer may Deny Payment, stating that the Charge is "not a covered benefit" under its policy or exceeds some other limitation. I further understand that a Payer may Deny Payment stating that the individual provider who actually renders the treatment or procedure is out-of-network. I also understand that a Payer may claim, based on internal criteria, that a particular Charge is or was not medically necessary or was not sufficiently documented, and should therefore be denied or downcoded. I also understand that a Payer may require certain Charges to be pre-certified or pre-authorized. I understand that there may be many other situations where a Payer may Deny Payment based on a particular contractual term applicable to me or to the Office (collectively, "Terms of Non-Coverage"). To the extent permitted by law or by contract, I agree that I am solely and exclusively responsible for verifying all Terms of Non-Coverage prior to incurring any Charges at the office. I agree that if I have any questions about the Terms of Non-Coverage, I can ask to see copies of the Office's verification (e.g., eligibility, pre-authorization) forms to gain further understanding. I further agree that should the Office assist me in any way in the verification, pre-authorization, or billing process, I assume the risk that the Payer and/or the Office may in my opinion not accurately understand and/or communicate the Terms of Non-Coverage and/or bill my Charges to my Payers. Should any Payer Deny Payment, or should any Payer be likely to Deny Payment as determined by the Office in its sole discretion, I agree that I am personally, fully, and immediately responsible for the portion of my Charges denied or likely to be denied. In no event shall I hold the Office responsible or liable in any of the foregoing instances.

Direction to the Office to Apply the Lowest Mandatory Fee Reduction When Two or More Payers Are Involved. Unless otherwise agreed to in writing, I authorize the Office to submit my Charges, as well as a copy of the Assignment & Lien, to any and all Payers, [not including in accident cases my health benefit plan or Medicare] [including without limit in accident cases my health benefit plan, but not including Medicare]. Notwithstanding the foregoing, in the event that the Office determines in its sole discretion that it has any reasonable basis for either submitting or not submitting my Charges and/or other documentation to a Payer, I hereby authorize the Office to take such action without condition or restriction. I understand that some or all of these Payers may utilize fee schedules which (a) the Office has agreed to accept, directly with said Payers in writing, or (b) law expressly imposes on the Office to accept (collectively, "Mandatory Fee Reductions"). I further understand that the Mandatory Fee Reductions imposed on the Office with respect to one Payer may exceed the Mandatory Fee Reductions imposed on the Office with respect to another Payer. In such an event, I hereby authorize and direct the Office insofar as permitted by law to apply the lower of the two Mandatory Fee Reductions to its Charges. I further agree that in the special event that Mandatory Fee Reductions are imposed on the Office by virtue of laws which regulate or restrict "balance billing," I hereby waive the application of such laws. In the event that no Mandatory Fee Reductions are actually imposed on the Office with respect to a Payer, I authorize and direct the Office to collect up to its full Charges from such Payer.

Authorization to Sign My Name on Payments; Transfer of Credit Balances. I authorize the Office to endorse or sign my name on any and all payments listing me as a payee which are received by the Office for payment of Charges incurred by me, my spouse or my dependents. In such cases, my printed name, followed by the phrase, "(by Roosevelt Chiropractic)," shall serve as a properly authorized endorsement. I further authorize the Office to apply any credit balances on my Charges to any other outstanding Charges still owed by me, my spouse, or my dependents, regardless of whether these other Charges are related to my condition.

Miscellaneous Provisions. Except as provided in this paragraph, this Agreement shall not be modified or revoked without the expressed, written consent of the Office. I hereby revoke, with the Office's consent, the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this Agreement. I agree that each and every provision of this Agreement is reasonably necessary. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect. This Agreement shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. In any action based upon this Agreement, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum inconvenience. I further waive any statute of limitations which may apply in any action based upon this Agreement. I have reviewed the Office's "Assignment & Lien" and Health Insurance Election forms and further agree to the terms and definitions set forth in these documents. Said documents are incorporated herein by reference. In the event that my condition is related to an accident, including without limit automobile accident, I understand that there will be an administrative fee necessary to cover the costs of verifying multiple Payers, filing and terminating liens, and submitting notices of same to Payers.

I have read, understood, and agree to the terms of this Agreement.

Patient Name (print): _____

Patient Signature: _____ Date: _____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (please print): _____

Parent/Guardian Signature: _____ Date: _____

Mark S. Jyringi, DC, PS, Jeremiah Tibbitts, DC & Brian Stuck, DC
5029 Roosevelt Way NE, Ste 101A, Seattle, WA 98105
Phone: (206) 547-4427
Fax: (206) 547-3587

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 supporting 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 your 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 request. 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: _____

Roosevelt
CHIROPRACTIC

5029 Roosevelt Way NE, Suite 101A
Seattle, WA 98105
Phone: 206.547.4427

Health Insurance Election

(Accident and Non-Accident Cases)

How would you like for us to handle your health insurance? Please choose one:

☐ **Option 1 -- I Do Not Have Health Insurance / I Don't Want You to File My Health Insurance**

I want the services we discuss, but either I don't have health insurance or I don't want you to bill or submit paperwork to my health insurance. You may keep any health insurance which I may have and that I provide to you on file, but only for the purposes set forth in, and as consistent with, your Financial Policy. I understand that if my claims or forms are not submitted to my health insurance in a timely manner, my payer may decline to pay on my claims and I may not be able to appeal this decision.

☐ **Option 2 -- I Want You to File My Health Insurance and Also Help Me Verify My Benefits. I Agree to Pay My Co-pay, Co-insurance, and Amounts Towards My Deductible**

I want the services we discuss, but I also want you to bill my health insurance for an official decision on payment. Please help me verify any Terms of Non-Coverage. If I have any questions, I will verify my coverage on my own. You may ask to be paid now for estimated co-pays, co-insurance, deductibles and other Non-Covered amounts. I understand that these are just estimates. In the event that my health insurance delays or Denies Payment, I will be responsible for payment as described in your Financial Policy, but I understand that I will be able to appeal to my health insurance following its directions.

☐ **Option 3 -- I Want You to File My Health Insurance, But I'll Pay in-Full at the Time of Service or Pre-Pay. If Insurance Pays, You'll Give Me a Refund**

I want the services we discuss, but I also want you to bill my health insurance for an official decision on payment. However, you may ask to be paid now. If my health insurance does pay, you will refund any payments I made to you, less co-pays, co-insurance, and deductibles, and also discounts (Mandatory Fee Reductions) as described in your Financial Policy. In the event that my health insurance Denies Payment, I can appeal to my health insurance following its directions.

Important: I understand that in certain circumstances, the Office may have a policy of not filing health insurance or law may actually control or regulate the filing of insurance. This election will remain in effect until a new election is signed with the Office's consent. This election supersedes any prior health insurance election.

Patient Signature: _____ Date: ___/___/___

Patient Name: _____