CORNERSTONE CHIROPRACTIC

Name: ______________________ **Nickname:** ______________ **Date:** __________

Home Address ____ Apt. # __________

City ______________________ State __________ Zip ______________

Home Phone ______________ Cell Phone ______________ Email ______________________

Date of Birth ______________ Age ______ ❑Male ❑Female Social Security # ______________

Referred by: ❑Drive by/walk in ❑Insurance list ❑Website ❑Online (Circle one) Yelp, Google, Facebook, Other __________

❑Patient referral ❑Previous Patient ❑Another Provider ______________________

Occupation ______________________ Employed: ❑Full time ❑Part Time Student: ❑Full time ❑Part time

Patient Employer/School Name ______________________________________

Patient Employer/School Address ______________________________________

Marital Status: ❑S ❑M ❑D ❑W Spouse's Name ______________________

May we speak to your spouse/parent about your account ______________________

Person to contact in case of Emergency ______________________ Phone ______________

Have you ever been to a Chiropractor before? ❑Yes ❑No If yes, Doctor's Name ______________________

Date of last Chiropractic Visit ______________ Reason for Care ______________________

Date of last Chiropractic X-rays ______________ How long were you under care? ______________

Reason for this visit: ______________________________________

Is this related to: **☐Auto Accident** **☐Employment Accident** **☐Other Accident**

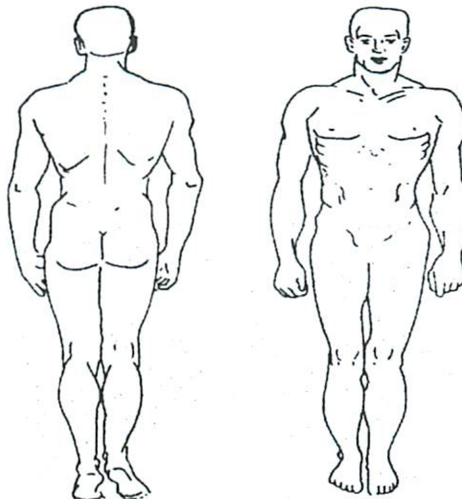
Name and address of other doctor(s) who have treated you for this condition:

____

____

Please mark the areas of your pain on the diagram below. Use the following letters to indicate the type and location of your pain.

A = Ache
B = Burning
P = Pain
S = Stabbing
N = Numbness
O = Other



List past surgeries and dates ____

List past accidents/traumas and dates ____

List any X-rays you have had in the last 2 years ____

List any diseases/conditions of family members (heart disease, stroke): ______________________________

Name and Age of Children ____

Social History and Daily Habits:

Do you sleep on your: ❑Back ❑Right Side ❑Left Side ❑Stomach?

Do you exercise? ❑Yes ❑No Type of exercise ______________________________ Frequency ______________

What do your daily work habits include? (Ex. sitting, standing, light labor, heavy labor, computer work)

____

Hobbies: ____

I understand the above and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any change in my health status.

Patient Signature ____ Date ______________

Insurance or Private Pay Information

Type of Insurance: ☐Private Insurance ☐Medicare ☐Auto Insurance ☐Other

Primary Insurance Carrier: ______________________ Insurance Provider Phone: ______________________

Patients ID Number: ______________________ Group Number: ______________________

Name of Policy Holder: ______________________ Relationship to Patient: ______________________

Policy Holder DOB: ______________________ Is patient covered by another insurance? ☐ Yes ☐ No

Secondary Carrier ______________________ Patients ID Number: ______________________

Claim Number: ______________________

Assignment/Authorization/Release

Insured Patient ☐ By checking this box, I certify that I, and/or my dependents, have insurance with the above-named insurance company(s) and assign directly to Cornerstone Chiropractic/ First Chiropractic all benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that 'copays' are payable at the time of each visit and that I am financially responsible for all charges whether or not paid by insurance. The above-named providers office may use my health care information and may disclose such information to the above-named insurance company(s) and their agents for the purpose of obtaining payment for services and determining benefits payable for related services.

It is the patient's responsibility to verify insurance benefits and notify the front desk of any changes in insurance benefits. When we speak to insurance companies, we are not always given correct or up-to-date information. We are not responsible for incorrect information given by your insurance company. The best way to verify information is by consulting your written insurance policy.

Private Pay/Cash Rate ☐ By checking this box, I acknowledge that I do not have insurance coverage and I clearly understand and agree that I am personally responsible for payment of any services rendered to me and charged directly to me.

Signature of person responsible for this account:

____

Printed Name of person responsible for this account:

____

CORNERSTONE CHIROPRACTIC
DR CAMERON LICHFIELD 2003 132ND ST SE, EVERETT, WA 98208

OFFICE POLICIES

1. Please be on time for your appointment. Being late, or last-minute cancellations will cause severe scheduling disruptions, which can interfere with the quality of care you and other patients receive.
2. The doctors will recommend a specific care plan for you. You are expected to follow the care plan. If you foresee difficulty following the care plan, please discuss it with the doctor prior to starting care. A certain number of visits in a set amount of time is required for us to get the results we both desire.
3. You may be charged for missed appointments or cancellations with less than 24 hours' notice. This will be the responsibility of the patient, not the insurance company. Continued cancellations, missed appointments, or failure to follow the recommended care plan may result in being released from care.
4. Children are welcome here as patients. If you bring children with you for your appointment, you are responsible for their actions at all times. Please have them accompany you to the adjusting room for your adjustment.
5. If you need to spend extra time discussing your health concerns with the doctor, please let our staff know prior to your appointment, so we may schedule your next appointment accordingly.
6. Please notify your doctor of any changes in your health status, regardless of the significance.
7. Walk-in patients are always welcome, however, patients with scheduled appointments will be seen first.
8. Payments and Co-pays are expected at the time services are rendered.
9. The patient is financially responsible for all services rendered to them in our clinic, regardless of insurance payment.
10. It is the patient's responsibility to verify insurance benefits and notify the front desk of any changes in insurance benefits. When we speak to insurance companies, we are not always given correct or up-to-date information. We are not responsible for incorrect information given by your insurance company. The best way to verify information is by consulting your written insurance policy.

Patients Signature ____

Printed Name ______________________________ Date ____________________

TERMS OF ACCEPTANCE • INFORMED CONSENT FOR CARE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care, we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____________________________ _________________________________ _______________

Print Name Signature Date

Consent to treat a Minor

I, ___________________________, being the parent or legal guardian of ___________________________________ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic evaluation (including X-ray examination) and care or massage therapy.

Signature____Date______________________________

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and I have been advised that x-ray can be hazardous to an unborn child.

Signature____Date______________________________