Krueger Chiropractic

1500 Sunset Hwy

East Wenatchee, WA 98802

PATIENT INFORMATION

PATIENT NAME

Last Name_______________ First Name_______________ Middle _______________

Gender: M F Date of Birth ___/___/___ Age______ SS#_______________

Home Address _______________ Apt # _______________

City _______________ State_______________ Zip _______________

Home Phone # _______________ Work Phone # _______________

Employer Name _______________ Occupation _______________

Employer Address _______________

City _______________ State _______________ Zip _______________

SPOUSE OR GUARDIAN

Last Name_______________ First Name_______________ Middle _______________

Date of Birth ___/___/___ SS#_______________

Home Phone # _______________ Work Phone # _______________

Employer Name _______________ Occupation _______________

EMERGENCY CONTACT

Last Name_______________ First Name_______________ Middle _______________

Home Phone # _______________ Work Phone # _______________

Relation to Patient _______________

PAYMENT INFORMATION

Person Responsible for Payment: _______________

Payment Method (for all services that are not paid by a third party)

☐ Cash ☐ Check ☐ Credit/Debit

INSURANCE INFORMATION

Do you have health insurance? ______Yes _______No

Primary Insurance	Secondary Insurance
Insurance Company:	Insurance Company:
Policy Holder's Name:	Policy Holder's Name:
Relationship to Patient:	Relationship to Patient:
Policy Holder's Birth Date:	Policy Holder's Birth Date:
Group Number:	Group Number:
Policy ID Number:	Policy ID Number:

Over ⇨

MY CERTIFICATION

I certify that the above information is correct and I request services.

X____ ________________________

Signature of patient or person acting on patients behalf Date

MY PRIVACY

I have received a copy of the **Notice of Privacy Practices**. I understand that 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 healthcare providers who may be directly in indirectly involved in providing my treatment; Obtain payment from third-party payors; Conduct normal healthcare operations such as quality assessments and accreditation.

X____ ________________________

Signature of patient or person acting on patients behalf Date

Patient Intake Form

Patient information contained within this form is considered strictly confidential.

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

Name: ______________________ **Date:** ________ (dd/mm/yr)

Insurance: ______________________

Date of Birth: ______________________ ☐ male ☐ female

Address: ______________________

____

____

Marital status

S	M	W	D	SEP

Phone #: home: ____________ **work:** ____________

E-mail address: ______________________

Occupation: ____________ **Employer:** ____________

Mark (c) for current problems, check ☑ and indicate the age when you had any of the following:

General
- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Mental illness
- ☐ Nervousness
- ☐ Tremors
- ☐ Weight loss / gain

Muscle / Joint
- ☐ Arthritis / rheumatism
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Muscle weakness
- ☐ Low back pain
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Joint pain

Skin
- ☐ Boils
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or allergies
- ☐ Itching
- ☐ Rash
- ☐ Varicose veins

Eye, Ear, Nose & Throat
- ☐ Colds
- ☐ Deafness
- ☐ Ear ache
- ☐ Eye pain
- ☐ Gum trouble
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Ringing of the ears
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsilitis
- ☐ Vision problems

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloody or tarry stool
- ☐ Colitis / Crohn's
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Diverticulosis
- ☐ Bloated abdomen
- ☐ Excessive hunger
- ☐ Gallbladder trouble
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Painful defication
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

Genitourinary
- ☐ Bed-wetting
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Prostate trouble
- ☐ Pus in urine
- ☐ Stress incontinence

Urination
- ☐ Overnight more than twice
- ☐ More than 8x in 24hrs
- ☐ Decreased flow/force
- ☐ Painful urination
- ☐ Urgency to urinate

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hardening of the arteries
- ☐ Irregular pulse
- ☐ Pain over heart
- ☐ Palpitation
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Swelling of ankles

Respiratory
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Hay fever
- ☐ Shortness of breath
- ☐ Spitting up phlegm / blood
- ☐ Wheezing

Women only
- ☐ Congested breasts
- ☐ Hot flashes
- ☐ Lumps in breast
- ☐ Menopause
- ☐ Vaginal discharge

Menstrual flow

☐ Reg. ☐ Irreg. ☐ Pain / cramps

Days of flow: ____ Lenght of cycle: _____

Date - 1st day last period: ____________

Are you pregnant? ☐ yes, ☐ no

If yes, how many months? _____

How many children do you have? _____

Birth control method: ____________

Date of last PAP test: ____________

☐ normal, ☐ abnormal

Date of last mamogram: ____________

☐ normal, ☐ abnormal

Check any of the conditions you have or have had:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cold sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart burn
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Numbness/tingling
- ☐ Pace maker
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers

Please list any medication you are currently taking and why:

____

____

____

____

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Patient Intake Form (side 2)

Give a breif detailed description of the problem you are currently experiencing: ____________________

____

____

____

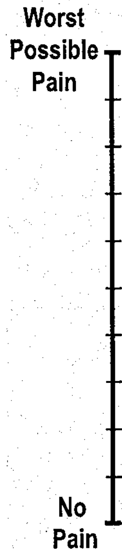
How long have you had this condition? ____________ Is it getting worse? ☐ yes, ☐ no ____________________

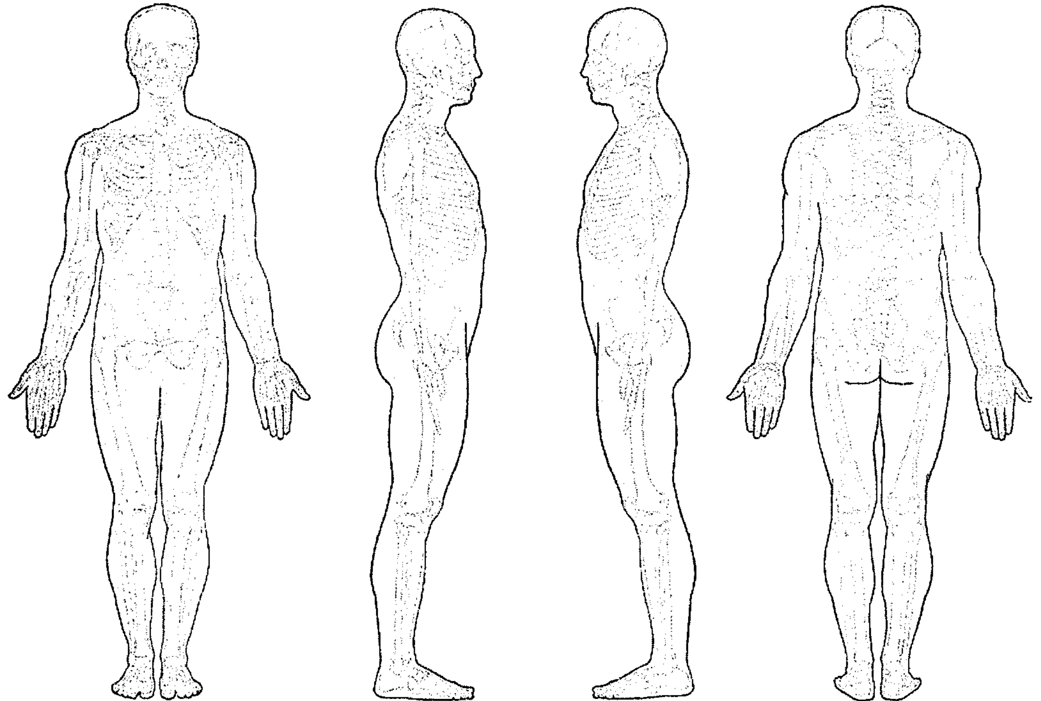
Does it bother you (check appropriate box): ☐ work, ☐ sleep, ☐ other: ____________________

What seemed to be the initial cause: ____________________

Please mark you area(s) of pain on the figure below

Please place a mark at the level of your pain on the scale below:





Past health history

Have you...	Yes	No	If yes, explain breifly
... been hospitalized in the last 5 year?	☐	☐	____________
... had any mental disorders?	☐	☐	____________
... had any broken bones?	☐	☐	____________
... had any strains or sprains?	☐	☐	____________
... ever used orthotics?	☐	☐	____________
Do you take minerals, herbs or vitamins?	☐	☐	____________

How is most of your day spent? ☐ standing, ☐ sitting, ☐ other: ____________

How old is your matress? ____________

When was your last physical exam? ____________

Habits	none	light	mod.	heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Soft drinks	☐	☐	☐	☐
Salty foods	☐	☐	☐	☐
Water	☐	☐	☐	☐
Sugar	☐	☐	☐	☐

Family history

If any blood relative has had any of the following conditions, please check and indicate which relative(s)

☐ Alcoholism	☐ Cancer	☐ High blood pressure
☐ Anemia	☐ Diabetes	☐ High cholesterol
☐ Arteriosclerosis	☐ Emphysema	☐ Multiple sclerosis
☐ Arthritis	☐ Epilepsy	☐ Osteoporosis
☐ Asthma	☐ Glaucoma	☐ Stroke
☐ Bleed easily	☐ Heart disease	☐ Thyroid disease

Do you have any other health issues or concerns that our staff should be made aware of? ____________________

____

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INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

Krueger Chiropractic PLLC:

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc.on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

____
Printed name of Patient

x______________________________ ______________
Signature of Patient Date

x______________________________ ______________
Signature of Representative Date
(if patient is a minor or is handicapped)

x______________________________ ______________
Witness to Patient's Signature Date

KRUEGER CHIROPRACTIC
NOTICE OF PRIVACY PRACTICES
SUMMARY

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. IF YOU HAVE QUESTIONS OR DO NOT UNDERSTAND ANY PART OF THIS DOCUMENT, PLEASE ASK. PLEASE REVIEW IT CAREFULLY.

Effective April 14th, 2003, a new federal law called the Health Insurance Portability and Accountability Act of 1996 [HIPAA] creates new rights for patients of health care organizations. One of these rights is to information regarding the provider's privacy practices. Under federal regulations, we must provide you with a copy of the Notice of Privacy Practices and will ask that you sign a document stating that we have given the Notice to you. You may review the Notice immediately or at a later time. A full notice of your privacy rights and Privacy Practices of Krueger Chiropractic PLLC will be provided for you to review now or take with you. You should read it carefully because it explains:

- Generally how health information about you may be used,
- That we may use health information about you for treatment, to obtain payment for treatment with your authorization, as required by Washington State Law, for administrative purposes, and to evaluate the quality of care that you receive;
- That we will not disclose your information to others unless you tell us to do so, or unless the law authorizes us to do so;

You have rights with respect to the health information we have about you. These are:

- To request restriction on how we use your heath information;
- To review and retain a copy of your health record;
- To request communication of your information by alternative means at alternative locations;
- To request an amendment to information in our records that you think is in error;
- Revoke your authorization and request an accounting of records release;

You may file a complaint to Chris Krueger, Privacy Officer, at 1500 Sunset Hwy, East Wenatchee, WA 98802, 509-888-6977, and to the Department of Health and Human Resources if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Krueger Chiropractic Financial Policy

Our goal at Krueger Chiropractic is to provide you the highest quality care while maintaining affordability to you. We accept cash, checks, Visa, Mastercard, and Discover.

Insurance Coverage

At Krueger Chiropractic, we accept health insurance and participate as a preferred provider for many insurance companies. We will verify your insurance benefits for you; however, the benefits quoted to us by your insurance company are not a guarantee of payment. Even with insurance, most patients will have some out of pocket expense. Copays, coinsurance payments, payments for non-covered services, and payments applied to your deductible will be due in full at the time of service. Payments applied to your deductible and payments for non-covered services are eligible for the Time of Service Discount (see below).

Patients Without Insurance

Payment is expected in full at the time of service, unless other arrangements have been made. If you are unable to pay in full at the time of service, you will be billed for all charges and will not be eligible for the Time of Service Discount (see below).

Time of Service Discount

Payment in full at the time of service reduces the charge for adjustments to $60 and all other charges by a set percentage. The discount is available to everyone. This does not apply to insurance copays or coinsurance. This discount applies if the payment is made before the office closes on the day you received care.

Financial Hardship Policy

At Krueger Chiropractic, we understand that healthcare and health insurance can be expensive. We do not want the cost to prevent you from receiving the care you need! We can determine more affordable payment options using a sliding scale based on your household income and the number of people living in your household. Please let us know if you would like to pursue this option.

Medicare Coverage

We accept assignment from Medicare. Medicare only covers the adjustment of the spine. Payment must be made for non-covered services at the time of service. Medicare pays 80% of their approved amount once the annual deductible has been met. The remaining 20% is due at the time of service. If the deductible has not been met, payment in full is due at the time of service. The amount you owe will be different if you have supplemental Medicare coverage. Please let us know if you have supplemental Medicare insurance.

Release of Information

I hereby authorize Krueger Chiropractic to release any information that is deemed appropriate concerning my physical condition to my insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred for services rendered to me at Krueger Chiropractic. I also authorize my insurance carrier(s) to make payment for services rendered directly to Krueger Chiropractic.

I have read and understand this financial policy. I realize that I am responsible for all charges incurred by me at Krueger Chiropractic. I agree to the above terms.

Patient Name (Print) ____________________ Date __________

Guardian Name (Print) ____________________ Date __________

Patient or Guardian Signature ____________________ Date __________