Champion Chiropractic and Wellness Center, Inc.

Patient Registration Form

Patient Information

Date:_____

Patient Name_____ _____ _____
Last First MI

Address_____
Street Address City State Zip Code

Sex ○ Male ○ Female Date of Birth_____ Social Security Number_____

Home Phone ( )_____Cell ( )_____ Work ( )_____

Occupation _____ Employer/School_____

Spouse Name_____ _____ _____
Last First MI

Spouse Date of Birth_____ Spouse Employer_____

In case of emergency, Contact:_____Relationship_____

Emergency Contact Number; ( )_____

Who may we thank for referring you?_____

Insurance Information

Who is financially responsible for this account_____ Relationship to patient_____

Insurance Company _____Plan #_____

Is patient covered by additional insurance? Yes No Subscribers SS#_____

Secondary Insurance

Subscriber's Name._____ Subscriber's Date of Birth_____

Subscribers SS#_____ Subscriber's relationship to patient_____

Insurance Company Name_____ Insurance Plan #_____

Assignment and Release

I certify that I, and/or my dependents, have insurance coverage with _____ and assign directly to Dr. Sandifer 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 doctor may use my health care information and may disclose said information to the above named insurance company, the Washington State Insurance Commissioner, and their agents for the purpose of obtaining payment for services, handling disputes and determining insurance benefits payable for related services.

_____ _____
Name of Financially Responsible Party (Please Print) Signature of Financially Responsible Party

_____ _____
Relationship to Patient Today's Date

Champion Chiropractic Center, Inc.
Confidential Patient Information

First Name:_____ Last Name:_____ Initial _____ Date_____

Major Complaint Information

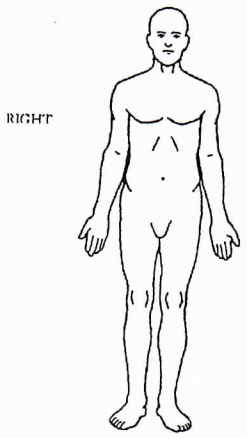
What is your major complaint(s)?_____

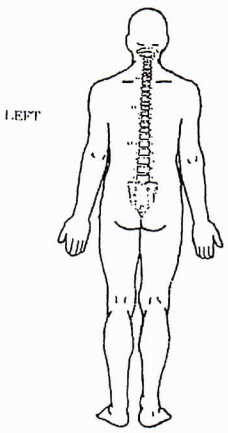
_____

When did this symptom(s) begin?_____

If this is an injury, describe what happened?_____

Using the symbols provided in the Pain Index, mark the areas on the illustrations below where you are experiencing pain, followed by a number from 1 to 10 indicating the extent of the pain. (1 being minor, 10 being severe)





Pain Index

D Dull Nagging Ache
B Burning
S Sharp / Stabbing
N Numbness / Tingling
M Muscle Spasm / Pulling

For example: if you are experiencing moderately severe burning pain in back of your neck, you should note a "B8" on the neck of the illustration.

On a scale of 1-10, how do you feel now? (1 being best, 10 being the worst)

1 2 3 4 5 6 7 8 9 10

Have you experienced these symptoms before? ○Yes ○No When?_____

What aggravates this condition?_____

What decreases the symptoms/pain?_____

Have you seen another doctor for this condition ○Yes ○No Doctor's Name:_____

Date consulted:_____ Diagnosis_____

Does this condition interfere with your sleep? ○Yes ○No If so, how many times do you wake up in pain per night? _____

In what position do you sleep? ○Back ○Side ○Stomach

Do you sleep with a pillow? ○Yes ○No How many?_____

Does heat affect the pain? ○Yes ○No If so, how?_____

Does cold affect the pain? ○Yes ○No If so, how?_____

Do you wear a heel lift? ○Yes ○No If so, which side? ○Right ○Left

Does it cause pain to cough, grunt, or sneeze? ○Yes ○No If so, where?_____

Check the activities below that create difficulty or pain:

○Lying on back
○Lying on side
○Turning over in bed
○Laying Flat On Stomach
○Climbing Stairs
○Getting in/out of car
○Dressing Self
○Sexual Activity
○Pushing
○Balance
○Other_____
○Pulling
○Reaching
○Kneeling
○Stooping
○Gripping
○Sitting
○Bending Forward
○Bending Backward
○Walking
○Chewing
○Standing For Periods Of Time
○Sneezing
○Coughing
○Turning Head Side To Side

Lying on Stomach

Lower Back Pain

Does the pain radiate into the legs? ○Yes ○No ○Right ○Left ○Both Does pain radiate to the abdomen? ○Yes ○No

Do you ever have impairment of bowel or urinary function? ○Yes ○No Explain:_____

Do you have numbness or tingling into the legs? ○Yes ○No Explain:_____

Neck Pain

If you have a neck injury, does it affect: (Check all that apply) ○Hearing ○Vision ○Balance ○Ringing or Vibration in your ears
Do you hear grating sounds? ○Yes ○No Do you feel pressure or pain behind your eyes? ○Yes ○No
Does pain radiate into the arm? ○Yes ○No ○Right ○Left ○Both
Are you at risk for a stroke? ○Yes ○No ○Don't Know
Do you have difficulty lifting or turning your head ○Yes ○No If so, in which direction? ○Right ○Left ○Up ○Down

Headaches/Migraines

Do you get headaches? ○Yes ○No Frequency_____ Do you have a family history of headaches? ○Yes ○No
Do you experience the following with your headaches/migraines:
Pain or cracking in your jaw? ○Yes ○No Nausea or Vomiting? ○Yes ○No Do you see ○sparks ○lights ○auras?
Did you have braces? ○Yes ○No Oral Surgery? ○Yes ○No Do you clench or grind your teeth? ○Yes ○No
Do you wear a night guard? ○Yes ○No Abnormal blood pressure? ○Yes ○No ○High ○Low
Do you use sugar substitutes? ○Yes ○No How frequently? ○Daily ○1-2 times a week ○3-5 times a week ○Occasional
Have you had any major head trauma in your life? ○Fall ○Auto Accident ○Concussion ○Hit/Blow to the head When?_____
When was your last eye exam by a doctor? ○1-6 months ○6-12 months ○1-2 years ○over 2 years Results:_____

Medical Information

If female, are you pregnant? ○Yes ○No ○Not Sure If yes, what is your due date?_____

List all medications that you are currently taking, including over the counter medication._____

List all herbal and vitamin supplements that you are currently taking._____

List all your allergies_____

Have you ever had any surgeries or hospitalizations?○ Yes ○No Please List:

Type of Hospitalization/Surgery	Date	Type of Hospitalization	Date

Have you been x-rayed in the last 12 months? ○Yes ○No When?_____ What views were taken_____

Have you been seen by a chiropractor before? ○Yes ○No Name_____ Date_____

Do you have a family physician? ○Yes ○No Name_____ Phone_____

Address_____ City_____ State_____ Zip_____

Family Medical History: Please list any diseases or medical problems of siblings, parents and grandparents _____

Have you ever had? ○Motor Vehicle Injury ○Sports Injury ○Work Injury ○Slip and Fall Injury If yes, please explain_____

Additional Complaints

Please check all that apply to you

○Loss of Concentration
○Eyes Sensitive to Light
○Memory Loss
○Heavy Feeling of Head
○Dizziness
○Ringing in Ears
○Loss of Balance
○Pins & Needles
○Loss of Smell
○Tension
○Speech Difficulty

○Neck Stiffness/Pain
○Neck Motion Restricted
○Upper Back Pain
○Mid Back Pain
○Right/Left Shoulder Pain
○Right/Left Arm Pain
○Right/Left Leg Pain
○ Fatigue
○Loss of Taste
○Chest Pain
○Sleep Disruption

○Shortness of Breath
○Irritable
○Anxiety
○ Depression
○Insomnia
○Excess Perspiration
○Vision Problems
○Digestive Trouble
○Pain Behind Eyes
○Feet/Toe Numbness
○Other

○Cold Hands
○Cold Feet
○Jaw Pain
○Hypertension
○Seizures
○Sinus problems
○Snore
○Nausea
○Palpitation
○Hand/Finger Numbness

○Arthritis
○HIV(Aids)
○ADD
○Diabetes
○Erectile Dysfunction
○Low Sex Drive
○Fainting
○Vomiting
○Nervousness

○Autistic
○Cancer
○ADHD
○Anemia
○Stroke
○Heart Disease
○Chest Pain
○Diarrhea
○Constipation
○Leg Pain

Do you have, or have you ever had, any diseases or medical problems not listed? ○Yes ○No If so, please list:_____

_____

Any Additional information you would like the doctor to know about before beginning care at Champion Chiropractic Center, Inc.:_____

_____

_____

I certify that the above information is correct to the best of my knowledge. By the signature below I hereby authorize and consent to chiropract treatment by Dr. Steven Sandifer of Champion Chiropractic Center, Inc. A photocopy of this authorization shall be considered valid as the original. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and m disclose said information to my insurance company, the Washington state Insurance commissioner, and their agents for the purpose of obtainin payment for services, handling disputes and determining insurance benefits or the benefits payable for related services.
I authorize that all payments go directly to Dr. Steven Sandifer.

Patient/Guardian Signature_____ Date:_____

Relationship to Patient_____

Please print name:_____

2405 Evergreen Park Dr. SW #B1, Olympia, WA. 98502 ♦Office (360) 438-6559 ♦Fax (360) 352-4204
www.championchiropracticcenter.com ♦ NPI 1467526244

Champion Chiropractic and Wellness Center, Inc.

Financial Policy

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately each visit you were seen for, the payments made by your insurance company to those dates, any contract adjustments; other adjustments if applicable, co-pays and other payments you have paid, and finance charges, if any. For any balance paid the previous billing cycle, these visits will not appear on future statements.

Payment if you have no insurance: Payment is due in full at the time of service for each service that you have per office visit.

Payment if you have insurance: We will bill your insurance if we are providers with them. Please check with us or your insurance company to see if we are providers. Not all of our providers are contracted with the same insurance companies. You are responsible for all charges not paid by your insurance company.

Payments: Unless other arrangements are approved by us, the balance on your statement is due and payable when the statement is issued, and is past due if not paid at the time of service.

Charges to Account: We shave have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Contracted Insurances: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment or denial of payment from the insurance company. You are responsible for all charges not paid by your insurance company.

Non-contracted Insurances: Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You are responsible to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or authorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Finance Charge: A finance charge will be imposed on each item of your account which is not been paid within 30 days of the time item was added to the account. The **FINANCE CHARGE** will be computed at the rate of 1% per month **ANNUAL PERCENTAGE RATE** of 12% or $5.00 per month, whichever is larger. The finance charge on your account is computed by applying the periodic rate to the overdue balance of your account. The overdue balance of your account is calculated by taking the balance owed 30 days ago and then subtracting any payments or credits applied to the account during that time.

Required payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we must receive co-pays at the beginning of your visit. Unpaid co-pays will result in a $10 billing fee added to your monthly statement.

Returned checks: There is a fee (currently $60) for any checks returned by the bank.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account a collection agency, you agree to pay all of the collections costs which are incurred. If we have to refer a collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Thurston county, Washington.

Champion Chiropractic and Wellness Center, Inc.

Financial Policy

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to the credit reporting agency, the fact that you receive treatment at our office may become a matter of public record.

Divorce: In the case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for the subsequent charges. If the divorce decree requires the other parent to pay for all or part of the treatment cost, it is the authorizing parent's responsibility to collect from the other parent.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee if you want to have copies of your records sent to another doctor organization. The amount of the fee is dependent on the number of pages we need to copy. You authorize us to include all relevant information, including your payment history. If you're requesting your records to be transferred from another doctor organization to us, you authorize us to receive all relevant for mission, including your payment history.

Worker's Compensation: We require a written approval/authorization or your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you'll be responsible for payment in full.

Personal Injury: Our financial relationship is with you, not your insurance company. It is imperative that you understand that you are the one ultimately responsible for your bill. It is the patient's responsibility to dispute your insurance company's decision by calling your claims manager. If your insurance company has not made a payment within 60 days or is withholding payment, for any reason, you will be personally responsible for any outstanding balances on your account. You also authorize Champion Chiropractic Center, Inc. to turn your claims into the Washington State Insurance Commissioner for assistance on payment of unpaid claims. If you reach the maximum benefits for your personal injury claim, you'll be responsible for obtaining an attorney before any further treatment is provided. You will also be responsible for making a minimum monthly payment on your account until settlement of your claim. A payment plan will be created by the financial manager to meet patient and office needs.

Missed Appointments and Late Cancellations: Our doctors and therapist value your time and request that you value theirs. The first missed appointments not kept, canceled, and/or rescheduled at least 24 hours prior to the scheduled appointment time will receive a warning, a second will be a $25 fee. Any missed appointments thereafter will be $52 each. These charges cannot be built your insurance company and will be a responsibility. Missed appointment fee's must be paid at the next scheduled appointment.

Printed Name: _____ Date: _____

Signature: _____ OM Initials: _____

Champion Chiropractic Center, Inc.
Informed Consent To Chiropractic Adjustments and Therapeutic Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Steven L. Sandifer and/or his preceptor and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with, or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor named below and/or other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, stroke, dislocations, sprains/strains, physiotherapy burns, and soft tissue injury. These complications are extremely rare occurrences. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. I understand that there are other forms of treatment, including but not limited to, drugs, surgery, physical therapy, acupuncture or opting out of any and all treatment. But, at this time, I choose to have chiropractic care.

Chiropractic treatment involves the science, philosophy and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use his hands or a mechanical device upon my body to adjust a joint, and there may be an audible "pop" or "click" as a result of joint movement. It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which he feels at the time to be in my best interest. Neither the practice of chiropractic or medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases.

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party payer can verify that services billed were actually provided.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the Practice reserves the right to change their notice and practices and prior to implementation, will mail a copy of any revised notice to the address I've provided or forward a copy in via e-mail at my request. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may by used or disclosed to carry out treatment, payment, or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent, in writing, except to the extend that the Practice has already taken action in reliance thereon.

I have read, or have had read to me, the Informed Consent to Chiropractic Adjustments and Care. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

_____ _____

Name (Printed) Date Signed

_____

Signature: Patient or legal Representative (Attorney, Guardian, Parent)

_____

Witness to Patients' Signature

Champion Chiropractic and Wellness Center, Inc.
Receipt of Privacy Practices

Your health care information is state mandated to be kept private from any and all parties. Champion Chiropractic Center, Inc., has a brochure that tells me how my health information is taken care of. This brochure is called "Notice of Privacy Practices". Champion Chiropractic Center, Inc., provided me with the most current "Notice" and may update this "Notice" at any time. Any updates to the "Notice" will be posted in the office. (Please initial each statement that you agree upon).

1. _____I have been given a current brochure of the "Notice of Privacy Practices" which describes how my health care information will be used and disclosed to carry out treatment, payment and health care operations.

Or

2. _____I have been informed how my health care records and information will be kept private, and I choose not to take a brochure at this time.

Also

3. _____I give Champion Chiropractic Center, Inc., staff permission to call me on the phone to make reminder calls or to discuss my account information.
4. _____I agree that messages may be left on my answering machine or voice mail.

The following people may obtain my medical information in case of my absence, hospitalization, or incapacitation:

_____ Relationship_____

_____ Relationship_____

_____ Relationship_____

_____ _____

Patient or Legally Authorized Individual Signature Today's Date

_____

Relationship to patient if signed on behalf of the patient by parent, legal guardian, etc.

Champion Chiropractic and Wellness Center, Inc.
Missed Appointment Financial Policy

We make every attempt to respect our patient's time by scheduling appropriate times for treatment and minimizing the amount of time a patient waits for care.

Everyone at Champion Chiropractic Center works very hard to provide excellent customer service. Since missed and late appointments greatly interfere with our ability to care for our patients we have the following policies:

If a patient is unable to keep their scheduled appointment, they must notify the office 24 hours in advance for Chiropractic, Massage Therapy, and Clinical Nutrition.

Appointments cancelled the same day as they are scheduled is considered a missed appointment. While calling just before your appointment time is better than not showing up, the end result is the same.

If a patient is arrives more than 10 minutes late for an appointment, they have missed their appointment. We will try to fit them in around other scheduled patients but it may involve a wait.

Your failure to notify the office of your intention to cancel and reschedule within the listed time frame, for each profession, will result in the following fees:

- Chiropractic $52.00
- Massage Therapy $62.00
- Clinical Nutrition $25.00

Please Note: Medical Insurance, Auto Insurance, and Workers Compensation **WILL NOT** cover these charges.

All fees are subject to monthly finance charges. All fees are subject to change without notice.

Printed Name: _____ Date: _____

Signature: _____ OM Initials: _____

Champion Chiropractic Center

2405 Evergreen Park Dr. SW #B1 Olympia, WA 98502
Phone (360)438-6559 Fax (360)352-4202

Current Medications

Please list all medications, supplements, herbal, injections, patches, drops and over the counter products etc. you are taking including dosage. Please include the ones you take on occasion.

Medication Name	Dosage	How often do you take?	Reason	Start Date