

# Champion Chiropractic and Wellness Center, Inc.

## Patient Registration Form

### Patient Information

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
Last First Middle Initial

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 Middle Initial

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 ( ) Subscriber's SS#: \_\_\_\_\_

### Secondary Insurance

Subscriber's Name: \_\_\_\_\_ Subscriber's Date of Birth: \_\_\_\_\_

Subscriber's 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 and Wellness Center, Inc.

## Confidential Patient Complaint Form

Date: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

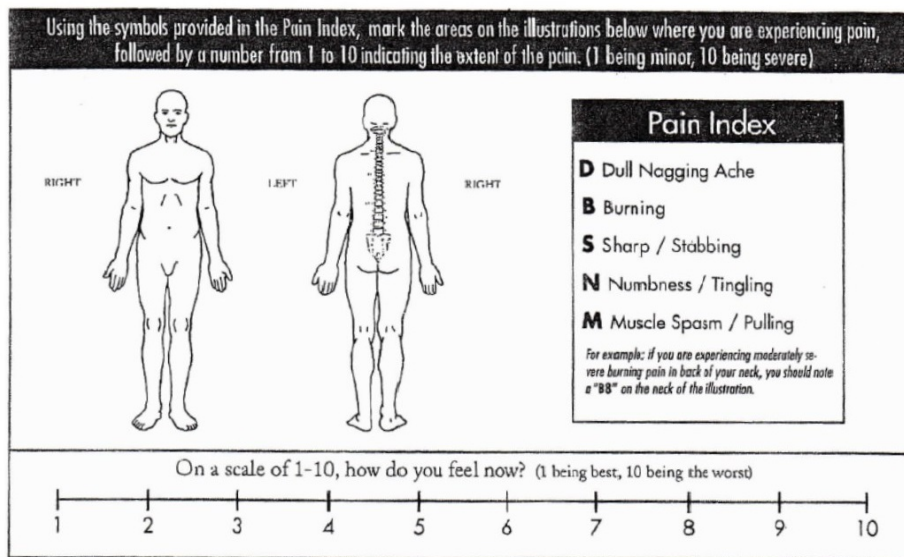
### Major Complaint Information

What is your major complaint(s) and specific area(s) of pain? \_\_\_\_\_

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)



The form contains two human diagrams: a front view and a back view. The front view is labeled 'RIGHT' on the left side and 'LEFT' on the right side. The back view is labeled 'LEFT' on the left side and 'RIGHT' on the right side. To the right of the diagrams is a 'Pain Index' legend with the following items:

- 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 "BB" 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? Ice \_\_\_ Heat \_\_\_ Stretching \_\_\_ Nothing \_\_\_ Other \_\_\_\_\_

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 \_\_\_ If so, 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, sneeze? Yes \_\_\_ No \_\_\_ If so, where? \_\_\_\_\_

Check the activities below that create difficulty or pain:

- Lying on back       Getting in/out of car       Pulling       Sitting       Standing for periods of time
- Lying on side       Dressing self       Reaching       Bending forward       Sneezing
- Turning over in bed       Sexual activity       Kneeling       Bending backward       Coughing
- Lying on stomach       Pushing       Stooping       Walking       Turning head side to side
- Climbing stairs       Balance       Gripping       Chewing

Other: \_\_\_\_\_

Does the pain radiate into the legs? Yes \_\_\_ No \_\_\_ Right \_\_\_ Left \_\_\_ Both \_\_\_ Does the 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 in the 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 oral surgery? Yes \_\_\_ No \_\_\_ Do you clench or grind your teeth? Yes \_\_\_ No \_\_\_

Do you wear a night guard? Yes \_\_\_ No \_\_\_ 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 \_\_\_

Blood pressure: \_\_\_ High \_\_\_ Low

### Medical Information

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

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

Type of Hospitalization / Surgery / Transplants	Date	Type of Hospitalization / Surgery / Transplants	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you been x-rayed in the last 12 months? Yes \_\_\_ Not Sure \_\_\_ 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 \_\_\_ Work Injury \_\_\_ Slip and Fall Injury If yes, please explain: \_\_\_\_\_

### Additional Complaints and Diagnosis

Please check all that apply to you

- Loss of Concentration       Shortness of Breath       Cold Hands       Arthritis       Autistic
- Eyes Sensitive to Light       Irritable       Cold Feet       Cancer       Jaw Pain
- Memory Loss       Upper Back Pain       Anxiety       Leg Pain       Speech Difficulty
- Heavy Feeling of Head       Mid Back Pain       Hypertension       Diabetes       Dizziness
- Right/Left Shoulder Pain       Insomnia       Seizures       Stroke       Fatigue
- Ringing in Ears       Erectile Dysfunction       Sinus Problems       Heart Disease       Snore

- |   |   |  |                                       |  |
|---|---|--|---------------------------------------|--|
| <input type="checkbox"/> Loss of Balance        | <input type="checkbox"/> Right/Left Arm Pain      | <input type="checkbox"/> Vision Problems   | <input type="checkbox"/> Diarrhea     | <input type="checkbox"/> Nausea                |
| <input type="checkbox"/> Pins & Needles         | <input type="checkbox"/> Hand/Finger Numbness     | <input type="checkbox"/> Pain Behind Eyes  | <input type="checkbox"/> Nervousness  | <input type="checkbox"/> Vomiting              |
| <input type="checkbox"/> Loss of Smell          | <input type="checkbox"/> Feet/Toe Numbness        | <input type="checkbox"/> Digestive Trouble | <input type="checkbox"/> Constipation | <input type="checkbox"/> Heart Palpitation     |
| <input type="checkbox"/> Sleep Disruption       | <input type="checkbox"/> Seizures                 | <input type="checkbox"/> Bi-Polar          | <input type="checkbox"/> Depression   | <input type="checkbox"/> Headaches             |
| <input type="checkbox"/> Migraines              | <input type="checkbox"/> Thyroid Condition        | <input type="checkbox"/> Skin Conditions   | <input type="checkbox"/> Ulcer        | <input type="checkbox"/> Sinusitis             |
| <input type="checkbox"/> Hepatitis              | <input type="checkbox"/> Heart Condition          | <input type="checkbox"/> Emphysema         | <input type="checkbox"/> Asthma       | <input type="checkbox"/> Lung Condition        |
| <input type="checkbox"/> Lung Issues            | <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Diverticulitis    | <input type="checkbox"/> Colitis      | <input type="checkbox"/> SIBO                  |
| <input type="checkbox"/> Crohn's                | <input type="checkbox"/> Fibromyalgia             | <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Gout         | <input type="checkbox"/> Slow Wound Healing    |
| <input type="checkbox"/> Alzheimer's            | <input type="checkbox"/> Dementia                 | <input type="checkbox"/> Mold Poisoning    | <input type="checkbox"/> Neuropathy   | <input type="checkbox"/> Erectile Dysfunction  |
| <input type="checkbox"/> Bladder Disease        | <input type="checkbox"/> Kidney Disease           | <input type="checkbox"/> Polymyalgia       | <input type="checkbox"/> Lyme         | <input type="checkbox"/> Heavy Metal Poisoning |
| <input type="checkbox"/> Burning Mouth Syndrome | <input type="checkbox"/> Chronic Fatigue Syndrome |  |                                       |  |
- Any Other Complaints and Diagnosis: \_\_\_\_\_
- 

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

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I certify that the above information is correct to the best of my knowledge. By the signature below, I hereby authorize and consent to chiropractic 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 may disclose said information to my insurance company, the Washington State Insurance Commissioner, and their agents for the purpose of obtaining 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: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Please Print Name: \_\_\_\_\_

# 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 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 copay 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 pre-authorization, you are responsible for obtaining it. Failure to obtain the referral and/or pre-authorization 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 pre-authorization 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 has not been paid within 30 days of the time the 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 copays at the beginning of your visit. Unpaid copays will result in a \$10 billing fee added to your monthly statement.

**Returned Checks:** There is a fee for any checks returned by the bank. Currently, this fee is \$60.

**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 to a collection agency, you agree to pay all of the collections cost which we incurred. If we have to refer a collection of the balance to a lawyer, you agree to pay all lawyer's 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 the divorce or separation, the parent authorizing treatment for a child will be the parent responsible for the subsequent charges. If the divorce 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 information, 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.

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Office Manager Initials: \_\_\_\_\_

# Champion Chiropractic and Wellness Center, Inc.

## Missed Appointment Financial Policy

Our doctors and therapists value your time and request that you value their's. 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, Cold Laser Therapy, and Clinical Nutrition.

Appointments canceled 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 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 \$52.00
- Cold Laser Therapy \$52.00
- Clinical Nutrition \$52.00

**Please Note:** Missed appointment fees must be paid at the next scheduled appointment. 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: \_\_\_\_\_ Office Manager Initials: \_\_\_\_\_

# **Champion Chiropractic and Wellness 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 names 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 names below an/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, 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 science, philosophy and art of locating the 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 that 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 the 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 via email 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 be 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 extent 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-names 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 Patient's Signature



**Champion Chiropractic and Wellness Center, Inc.**

2405 Evergreen Park Dr. SW #B1, Olympia, WA 98502

Phone: (360) 438-6559 Fax: (360) 352-4202

**Current Medications / Supplements / Herbs**

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

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

**\*\* Please use back of page if additional space is needed for medication / supplements**

Please list all known allergies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_