Holt
chiropractic massage

PATIENT APPLICATION FORM

WELCOME and THANK YOU for applying as a patient in our clinic. We are a very unique team specialized in researched-based spinal and postural rehabilitation that helps our patients recover their optimal health; often where many other systems have failed. Because of this, we may not accept you as a patient until we are absolutely certain we know what is causing your condition, can perform the necessary tests to establish an optimal rehab program for you, and are completely confident we can help you recover your health. Please know if we do accept you as a patient, we will then make specific recommendations based on our understanding that your health will become your TOP PRIORITY. Thank you again for applying as a patient in our clinic.

PATIENT NAME _____

DATE COMPLETED _____/_____/_____

Patient information

Name _____ Birth date ____/____/_____ Age_____ Gender: _____

Height _____ Weight _____ Military (you or spouse): ☐ Yes ☐ No

Home address _____ Home phone (_____) _____

City, state, zip _____ Work phone (_____) _____

Email address _____ Cell phone (_____) _____

Current or past Occupation_____ Employer name_____

Social Security # _____ - _____ - _____ Marital status _____

Spouse's name (if applicable) _____ Spouse's Cell phone (_____) _____

How have you been referred to this office? ☐ Google ☐ Facebook ☐ Family/Friend ☐ Other_____

Purpose for the visit

1. **Reason for this visit:** _____

   Is this related to an accident or specific injury? (other than auto or work related?) Yes No If Yes when ___/___/___

   *If your symptoms are the result of an auto-accident or work-related injury, please ask the front desk for the corresponding application

2. **General symptom chart - Type of discomfort**

   Please use the following annotation on the figures to indicate the type and location of your symptoms, as it relates to the purpose of your visit today.

   A = Ache *F = Stiffness*

   M = Spasms *G= Stabbing*

   T = Tingling *P = Pins & Needles*

   B = Burning *N = Numbness*

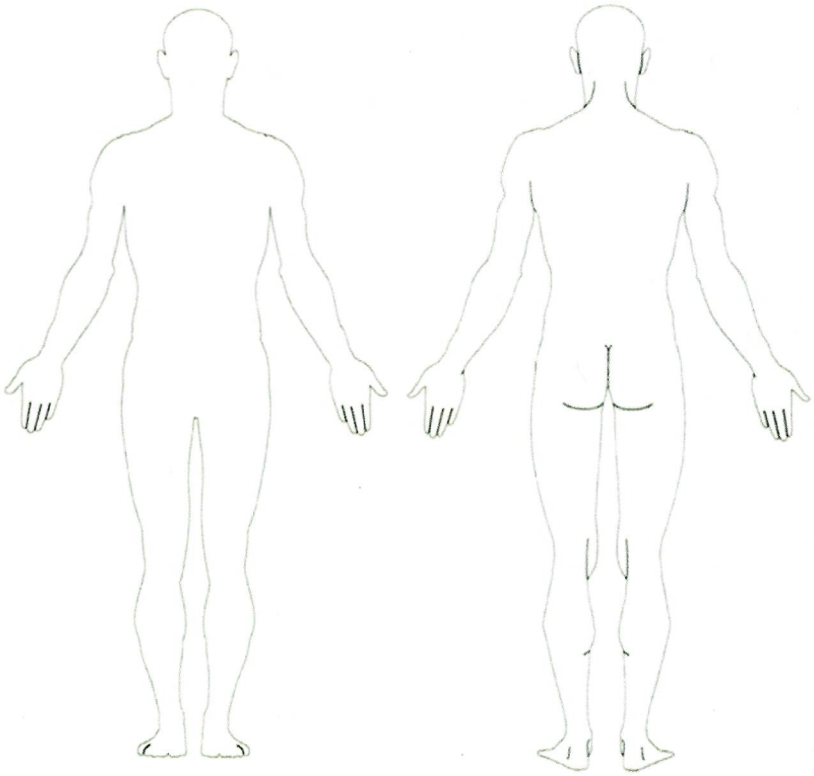
   O = Other

   If you marked "O", please explain:

   _____

   _____

   _____



FRONT BACK

3. **What is your pain intensity?** (From 0 to 10)

0	1	2	3	4	5	6	7	8	9	10
None		Mild			Moderate			Severe		Excessive

4. **Are your symptoms:** (% of the time)

Occasional 25% of the time	Intermittent 50% of the time	Frequent 75% of the time	Constant 100% of the time

5. When did these symptoms begin? _____
   - Are they getting worse? Yes No
   - Do they interfere with: Work Sleep Hobbies Daily Routine
   - Explain: _____
6. When are the symptoms most noticeable? Morning Afternoon Evening All day
7. What activities aggravate your symptoms? _____
8. Is there anything that relieves your symptoms? Yes No If yes, explain _____
9. Have you experienced these symptoms before? Yes No If yes, explain _____
   - Have you been treated for this? _____
   - Who did you see? _____
   - What treatment was performed? _____
   - How did you respond? _____

Health & Lifestyle

1- Social history

- Do you smoke? Yes No How much? / How often? _____
- Do you drink alcohol? Yes No How much? / How often? _____
- Do you drink coffee? Yes No How much? / How often? _____
- Do you take supplements? Yes No How much? / How often? _____
- Do you exercise? Yes No How much? / How often? _____

  What activities? Walking Weight training Yoga Other _____

2- Personal and Family history

Please indicate "Y" for You and "O" for Other than you, or "B" for both if applicable

___ Diabetes	___ Varicose veins	___ Neurological problems	___ Lung disease
___ Rheumatic Fever	___ Circulatory problem	___ Stroke	___ Heart Murmur
___ Heart disease	___ High Blood Pressure	___ Cancer	___ Osteoporosis
___ Kidney disease	___ Paralysis	___ Migraine Headaches	___ Arthritis
___ Liver disease	___ Metal implants	___ Infectious diseases	___ Gall Bladder
___ Appendectomy	___ Broken bones/Fractures	___ Tonsillectomy	___ Hernia
___ Polio	___ Pneumonia/Bronchitis	___ Tuberculosis	___ Anemia
___Whooping cough	___ Chicken pox/shingles	___ Mumps	___ Measles
___ Thyroid problems	___ Small pox	___ Flu	___ Pleurisy
___ Seizure	___ Blood sugar problems	___ Eczema/Psoriasis	___ Low Back Pain

Other: _____

3- Health condition

Your spine is the foundation of health and core strength in your body. Shifts in the vertebrae or sections of the spine will spread ultimately causing weakness and distortions to ALL the areas of the spine. These distortions are reflected in abnormal posture. Research shows abnormal posture leads to chronic pain, disease and possibly a shortened life span. Please answer the following questions accurately so we may determine the full extent of your condition.

Cervical spine (neck)

Misalignment of the individual vertebrae or distortion of the cervical curve (neck) originating in the neck or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

___ Neck pain
___ Dizziness
___ Visual disturbances
___ Hearing disturbance
___ Low energy/Fatigue
___ Headaches
___ Recurrent colds/flus
___ Sinusitis
___ Allergies / Hay fever
___ TMJ / Pain / Clicking in Jaw
___ Thyroid conditions
___ High Blood Pressure
___ Pain in shoulders/arms/hands
___ Coldness in hands
___ Numbness in arms/hands
___ Tingling in arms/hands
___ Weakness in the grip

Thoracic spine (upper back)

Misalignment of the individual vertebrae or distortion of the thoracic curve (upper back) originating in the upper back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

___ Heart Palpitations
___ Heart Murmurs
___ Tachycardia
___ Heart Attacks/Angina
___ Asthma/Wheezing
___ Shortness of breath
___ Pain on deep inspiration/expiration
___ Recurrent lung infections/Bronchitis

Thoracic spine (mid back)

Misalignment of the individual vertebrae or distortion of the thoracic curve (mid back) originating in the mid back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

___ Nausea
___ Ulcers/Gastritis
___ Indigestion/Heartburn
___ Reflux
___ Diabetes
___ Hypoglycemia/hyperglycemia
___ Tired/irritable after eating or when not having eaten for a while
___ Mid back pain
___ Pain in ribs/Chest

Lumbar spine (low back)

Misalignment of the individual vertebrae or distortion of the lumbar curve (low back) originating in the low back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

___ Sciatica
___ Constipation/Diarrhea
___ Sexual dysfunction
___ Recurrent bladder infection
___ Frequent/difficulty urinating
___ Menstrual pain/irregularities/cramping (females)
___ Low back pain
___ Pain in hips/Legs/Feet
___ Coldness in legs/feet
___ Numbness/tingling in legs/feet
___ Weakness in hips/knees/ankles
___ Muscle cramps in legs/feet

Others

- Please list any health conditions not mentioned:

_____

_____

_____

- Please list any medications (include name, dose, for what condition, and how long you have been taking it):

_____

_____

_____

- Please list any surgeries (include type of surgery and date it was performed):

_____

_____

_____

Experience with Chiropractic

1. Have you seen a chiropractor before? Yes No If yes, who? _____
   Reason for visit _____
   Did your previous chiropractor take 'before' and 'after' X-rays? Yes No
   Did he or she recommend a specific course of treatment? Yes No
   Did they recommend a home health care program? Yes No
   If Yes, what? How long were you treated? _____
   When was your last treatment? ___/___/___
   How did your respond? _____
2. Are you aware of any poor posture habits? Yes No
3. Is there any history of spinal problems in your family? Yes No

If yes, explain _____

Authorization of care

I authorize and agree to allow the doctor and/or his designated staff to work with my spine or the spine of the charge I represent through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal bio-mechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided and agree to ensure full payment of all charges.

The doctor and/or his staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another healthcare practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the doctor's and/or staff's specific recommendations at this clinic that I will not receive the full benefit from these programs; and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the doctor and/or staff for all services rendered.

Patient's signature _____ Date ___ / ___ / ___

Patient's name printed _____

If a patient is a legal charge of limited capacity requiring guardianship for treatment, please complete the following:

Date guardianship awarded _____

County, state of guardianship _____

I hereby authorize the doctor to administer care as deemed necessary to my charge as appointed by the courts.

Guardian's signature _____ Date ___ / ___ / ___

In case of emergency

Name _____ Relationship _____

Work phone ( ) _____ Cell phone ( ) _____

Home phone ( ) _____

Insurance

We may accept assignment of insurance benefits. By signing this policy, you agree to assign your insurance benefits to this clinic. In cases where benefits are not assignable or in any case where you benefit is processed directly to you regardless of assignment, you agree to submit any payments received along with the explanation of benefits to this clinic within 10 days of receipts unless you have paid for services represented by said payment in full at the time of service. In no case will an assignment alleviate you of your obligation for payment of services received.

Your insurance plan is a contract between you and your insurance company. This clinic is not a party to that contract and therefore cannot modify the terms of that contract. Payment for treatment that you receive from Holt Chiropractic & Massage is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with the necessary billing information, assign your benefits to this clinic and agree to permit us to release the necessary medical information required to secure payment. In the event that we do accept assignments of benefits, we require that you provide a credit card along with authorization to bill that account any balance or make other payment arrangements. We will make every effort to ensure that your insurance carrier properly processes your services for payments. In some circumstances we may require your assistance. If your insurance company has not paid your account in full within 60 days and you refuse to assist us in dealing with your carrier, the balance will automatically be transferred to your credit card or the extended payment plan.

NOTE: Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your insurance program. If you are unsure as to the nature of the service you are receiving, please ask your doctor. For coverage information, it is your responsibility, to review your benefit contract.

DECLARATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The Doctor's office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

I understand there could be some services that my insurance company does not cover. If this is the case I am willing to pay for these services. Yes No

Patient's signature _____ Date ___ / ___ / ___

Signature of person authorizing care (if different from patient):

_____ Date ___ / ___ / ___

Relationship to insured _____ Date of birth ___ / ___ / ___

Employer _____

*****If we have a copy of your insurance cards, you do not need to fill information out below*****

Primary insurance company _____ Policy # _____

Address _____ Phone # ( ) _____

Insured's name _____ Insured social security # _____ - _____ - _____

Secondary insurance company _____ Policy # _____

Address _____ Phone # ( ) _____

Insured's name _____ Insured social security # _____ - _____ - _____

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Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both parties to be working towards the same objective.
Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Here are a few important terms.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

We do not offer to diagnose or treat any disease or condition other than VERTEBRAL SUBLUXATION. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the body's nervous system. Our only method is specific adjusting to correct vertebral subluxations.

Disc Herniations: Disc Herniation (slipped disc) is a condition that creates pressure on the spinal nerves or on the spinal cord. Disc herniations are frequently successfully treated by chiropractors and chiropractic adjustments, traction etc. This includes herniations in both in the neck and back. Yet, occasionally, if the disc is in a weakened state, a chiropractic treatment (adjustment, traction, etc.) can aggravate a condition and cause a disc problem. These problems occur so rarely that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely a chiropractic adjustment, traction, massage therapy, etc, may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no available statistics to quantify their probability.

Rib Fractures: The ribs are found only in the thoracic spine or the muddle of the back. They extend from your back to your front chest area. Rarely, a chiropractic adjustment will crack a rib bone, and this is referred to as a fracture. This occurs only in patients who have weakened bones from such things as osteoporosis. Osteoporosis can be noted in your x-rays. We adjust all patients very carefully, and especially those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

Modalities: We sometimes recommend ice or heat for home care. Everyone's skin has different sensitivity to these modalities, and rarely, either heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain, and there may be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

Stroke: Stroke is the most serious problem associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. Chiropractic adjustments have been associated with strokes that arise from the vertebral artery only; this is because the vertebral artery is found inside the neck vertebrae. The adjustment related to vertebral artery stroke is called "extension-rotation-thrust atlas adjustment". We do NOT do this type of adjustment on patients. Other types of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. The most recent studies (Journal of the CCA Vol.37 No. 2, June 1993) estimate that the incident of this type of stroke is 1 per 3,000,000 upper neck adjustments. This means that an average chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

Soreness: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc. to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not always dangerous, but please do tell your doctor about it.

Other Problems: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, disease, or condition because of treatment in this clinic. We will always give you our best care, and if the results are not acceptable, we will refer you to another provider who we feel will assist your situation.

I, _____, have read and fully understand the above statements.
Print Name

All questions regarding the doctor's objectives pertaining to this form have been answered to my complete satisfaction. I authorize the staff to perform any necessary services needed during diagnosis and treatment such as: for health care operations, appointment reminders, treatment alternatives, health-related products and services, or any other special situations.

_____ _____ _____
Signed Date Parent or guardian's signature if patient is a minor

Authorization for X-rays

I give my permission for Dr. Holt, Dr. Ali or the certified X-ray technician at Holt Chiropractic to take X-rays.

_____ _____ _____ _____ _____
Signed Age I am NOT pregnant I AM pregnant Date

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Office Fee Schedule and Financial Policy

Service	Charge
Consultation	N/C
Initial Exam	$250
Re-Exam	$25-$170
X-Rays (averages)	$50-$330
Adjustment	$60, $70, $80
Posture Exercises	$30
Mechanical Traction	$40

Financial Policy & Chiropractic Platinum, Gold, & Payment Plans

We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time the service is rendered unless other financial arrangements have been made. We provide different prepay plans for your convenience. The Platinum Plan is designed to be the most cost-effective way to keep you and your family as healthy as possible. Details of these will be discussed with you at your Report of Findings.

Health Insurance: If you have medical insurance that covers chiropractic, we will help you find out the limits of your coverage and present a financial plan to you with your limits included with the plan. Remember, however, your agreement with your insurance company is between you and them.

Even if your insurance is not in our network, there may be coverage available. We are more than happy to provide you with a Superbill to send out to your insurance for possible reimbursement. We will discuss all options with you during your report of findings.

Cash: We accept Cash, Personal Checks, Visa, Amex, MasterCard and CareCredit. Once you have chosen your financial plan, we offer cash and pre-pay discounts as well as other convenient payment options.

If you acquire insurance for a special situation such as an auto accident or a worker's compensation injury and choose to utilize that coverage, you will be charged our regular office fees until such claim is settled.

I have read and I understand the above policies.

_____ _____

Signed Date

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Patient Privacy Summary

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS 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.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our Notice from time to time. The effective date at the top right hand side of this page indicates the date of the most current Notice in effect.

You have the right to receive a copy of our most current Notice in effect. If you have not yet received a copy of our current Notice, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the Notice or your medical information, please contact Dr. Tom Holt or Dr. Ali Burnside at 360-874-0232.

NOTE

Our clinic operates in a semi-open concept format. While we take the protection of your personal health information seriously, inevitably people in other parts of the clinic may overhear the conversations you have with Dr. Holt, Dr. Ali, or the team, If this makes you uncomfortable in any way, or if you have something confidential you need to tell Dr. Holt or Dr. Ali, please feel free to request an immediate private conference in the exam room.

I have read the above document and understand it fully. I have had all of my questions answered to my satisfaction.

_____ _____

Signed Print Name

_____ _____

Date Print Name of Minor

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Authorization for Assignment of Payment

I hereby authorize and assign payment directly to:

Holt Chiropractic & Massage, PS
1800 SE Mile Hill Dr. Ste 150
Port Orchard, WA 98366

for professional services rendered. I understand I am personally responsible for any unpaid balance to Holt Chiropractic and Massage. I hereby authorize the attending provider to release any information concerning my examination and/or treatment.

This form is used in lieu of the patient's signature on the HCFA 1500 form and is, therefore, an extension of that form.

_____ _____
Signed Date

Cancellation / no show fee

I understand my appointment times for all massages are reserved for me. Therefore, if I cancel any service appointment without a 24-hour notice or do not show for an appointment, I will be billed, or my credit card will be charged, a **$50.00** reservation fee for each service.

_____ _____
Signed Date