VALENTE CHIROPRACTIC

Patient Registration

Date: _____

Name: _____ _____ _____
Last First Middle

Nickname or Preferred Name: _____

Social Security # ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Address: _____

City _____ State _____ Zip _____

Cell Phone (_____) _____ - _____

Phone 2 (_____) _____ - _____ ☐ Home ☐ Work ext: _____ ☐ Other

E-mail Address: _____ @ _____ . _____

Please write your email address clearly to help ensure clinic communications are sent to the correct address.

Date of Birth: _____ / _____ /_____

Age: _____

Sex: □ Male □ Female □ _____

I would like to be notified of my upcoming appointments by:
- □ Text Message
- □ E-mail Message
- □ No Notification Please

How did you hear about us?

☐ Google/Web Search ☐ Family/Friend _____ ☐ Doctor/Provider Referral _____

☐ Facebook/Social Media ☐ Insurance company ☐ Sign/Building ☐Other _____

Marital Status:
- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Partnered for _____ years

Spouse/Partner name:

_____

Race:
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Other Pacific Inslander
- ☐ White
- ☐ Other _____
- ☐ Decline to Specify

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Decline to Specify

Preferred Language:

_____

Employment:

- ☐ Employed (FT)
- ☐ Employed (PT)
- ☐ Self-Employed
- ☐ Unemployed
- ☐ Homemaker
- ☐ Active Military
- ☐ Retired
- ☐ Disabled
- ☐ Full-time Student
- ☐ Part-time Student
- ☐ Other _____

Employer: _____

Occupation: _____

School: _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Home (_____) _____ - _____ Cell (_____) _____ - _____ Work (_____) _____ - _____

Accident/Injury Information

Is your condition due to an Auto Accident? ☐ No ☐ Yes Date: _____

Is your condition due to an injury sustained at Work? ☐ No ☐ Yes Date: _____

Is your condition due to another form of accident or personal injury? ☐ No ☐ Yes Date: _____

If YES please explain: _____

To whom have you made a report of your accident/injury:

☐ LNI or Workers Comp ☐ Employer ☐ Auto Insurance ☐ Other

Attorney Name : _____

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Patient Current Condition and Pain Form

Name _____ **Date** _____

Complaint/Pain Location(s) (example: neck, upper back, mid-back, low-back, hips, extremities):

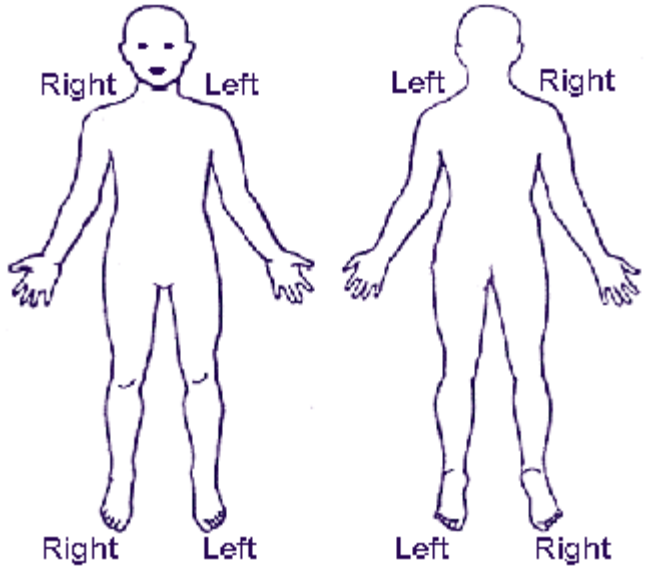
_____

Usual Pain Intensity

No pain 0 1 2 3 4 5 6 7 8 9 10 Severe pain

Today's Pain Intensity

No pain 0 1 2 3 4 5 6 7 8 9 10 Severe pain



Front Back

On the image please indicate where you are experiencing your symptoms.

How would you describe the character of your condition/pain? (please check all that apply)

☐Sharp ☐Dull ☐Tingling ☐Numb
☐Aching ☐Shooting ☐Radiating ☐Burning
☐Throbbing ☐Cramping ☐Stiffness ☐Swelling
☐Other _____

How often do you experience your symptoms?

☐ Constantly (76%-100% of the time)
☐ Frequently (51%-75% of the time)
☐ Occasionally (26%-50% of the time)
☐ Intermittently (0%-25% of the time)

When do you experience your symptoms?

Ex: every day, most days, some days, a few times a year

_____

Does your condition interfere with your.... (please check any that apply)

☐ Sleep ☐ Work ☐ Daily routine ☐ Recreational activities

	Comfortable	Uncomfortable	Painful
Lying down	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Stretching	☐	☐	☐
Walking	☐	☐	☐
Running	☐	☐	☐
Bending	☐	☐	☐
Lifting	☐	☐	☐
Kneeling	☐	☐	☐
Pulling	☐	☐	☐
Reaching	☐	☐	☐
Other _____	☐	☐	☐

Additional information / Any recent falls and/or injuries / Prior condition related medical history

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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Health History:

It will be assumed that any space left blank indicates that you have NOT had that test, exam, illness, disease, surgery, ect.

A. Date of last:

Physical Exam:	**Medical Doctor:**	**Bone Scan:**	**CT-Scan:**
Chiropractic:	**Chiropractor:**	**Spinal X-Ray:**	**MRI:**
Physical Therapy:	**Physical Therapist:**	**Chest X-Ray:**	**Blood Test:**
Massage Therapy:	**Massage Therapist:**	**Dental X-Ray:**	**Other:**

B. Injuries, traumas, allergies, and illnesses:

Broken Bones/Fractures: _____ Head Injuries: _____

Dislocations: _____ Falls: _____

Please check the box to indicate if you have or have had any of the following:

☐ **AID/HIV**	☐ Breast Lump	☐ Epilepsy	☐ Herpes	☐ Mumps	☐ Psychiatric Care	☐ Tuberculosis
☐ Alcoholism	☐ Bronchitis	☐ Glaucoma	☐ High Blood Pressure	☐ Osteoporosis	☐ Rheumatoid Arthritis	☐ Tumors, Growths
☐ Allergy shots	☐ Bulimia	☐ Goiter	☐ High Cholesterol	☐ Pacemaker	☐ Rheumatic Fever	☐ Typhoid Fever
☐ Anemia	☐ Cancer	☐ Gonorrhea	☐ Kidney Disease	☐ Parkinson's Disease	☐ Scarlet Fever	☐ Ulcers
☐ Anorexia	☐ Cataracts	☐ Gout	☐ Liver Disease	☐ Pinched Nerve	☐ STD(s)	☐ Vaginal Infections
☐ Appendicitis	☐ Chemical Dependency	☐ Heart Disease	☐ Measles	☐ Pneumonia	☐ Stroke	☐ Whooping Cough
☐ Arthritis	☐ Chicken Pox	☐ Hepatitis	☐ Migraine Headaches	☐ Polio	☐ Suicide Attempt	☐
☐ Asthma	☐ Diabetes	☐ Hernia	☐ Mononucleosis	☐ Prostate Problem	☐ Thyroid Problems	☐
☐ Bleeding Disorders	☐ Emphysema	☐ Herniated Disk	☐ Multiple Sclerosis	☐ Prosthesis	☐ Tonsillitis	☐

Other illness or injury: _____

Allergies (ex: seasonal, peanuts) &/or Medication Allergies (ex: Penicillin, NSAID):

_____ ☐ **NO Known Allergies**

_____

C. Surgeries:

Type of Surgery	Date	Surgeon/Hospital

D. Current Medications: (if certain attributes of your medication(s) are unknown, please write unknown)

Medications or Vitamins/Herbs/Minerals	Dosage (mg)	Frequency	Prescribing Doctor
☐ **NO Current Medications**			

E. Females- Pregnancies and outcomes:

Are you currently pregnant? ☐ No ☐ Yes **Due Date** : _____

Prior pregnancies, dates of delivery, and outcomes: _____

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2. What previous care/treatment have you received for your condition?

☐ Physical therapy ☐ Chiropractic care ☐ Medication ☐ Surgery ☐ None ☐ Other: _____
Have you ever received Chiropractic Care? ☐ Yes ☐ No If yes, when? _____

3. Family Health History:

Associated health problems of relatives _____

_____

_____

4. Social and Occupational History:

A. Level of Education:

☐ High school ☐ Some college ☐ College graduate ☐ Post graduate studies
☐ Currently attending _____

B. Job description, work schedule, and work activity (eg: sitting, standing, light/heavy labor):

_____

_____

C. Habits:

Do you smoke or use tobacco products?
☐ Current Every Day Smoker ☐ Current Some Day Smoker ☐ Former Smoker ☐ Never Smoker
☐ Other: _____

Do you consume alcohol? ☐ Yes ☐ No
Amount:_____

Do you consume coffee or other caffeinated drinks? ☐ Yes ☐ No
Amount:_____

Are you under a lot of stress? ☐ Yes ☐ No
Reason:_____

D. Recreational activities:

_____

_____

F. Exercise:

Type(s):_____
(e.g: walking, running, aerobic activities, yoga, rock climbing, pool activities, softball, core training, weight lifting)

Frequency:_____
(e.g: 3 times a week, daily, twice daily, rarely, never)

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize Dr. Valente/Valente Chiropractic to provide me with chiropractic care, in accordance with Washington state's statutes.

Signature _____ Date _____

Printed Name: _____

Doctor's Signature _____ Date _____

VALENTE
CHIROPRACTIC

Assignment of Benefits and Release of Information

HEALTH COVERAGE INFORMATION

Primary Health Insurance	Secondary Health Insurance (if any)
Insurance Company: _____	**Insurance Company:** _____
Member / ID No.: _____	**Member / ID No.:** _____
Group No.: _____	**Group No.:** _____
Subscriber Name: _____	**Subscriber Name:** _____
Subscriber Birthdate: _____	**Subscriber Birthdate:** _____
Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____	**Patient Relationship to Subscriber:** ☐ Self ☐ Spouse ☐ Child ☐ Other _____

AUTO / WORKERS' COMPENSATION CLAIM INFORMATION

Date of injury: _____ **Attorney (if applicable):** _____

☐ **1st Party Auto**	☐ **3rd Party Auto**	☐ **Workers' Comp / L&I**
Your auto insurance	*Other party's auto insurance*	Claim no.: _____
Claim no.: _____	Claim no.: _____	Employer: _____
Auto insurer: _____	Other insurer Co.: _____	Claim manager: _____
Personal Injury Protection:	**If no PIP or after PIP is Exhausted:**	**My Employer is insured with:**
☐ I have PIP/Med Pay on my policy	☐ Bill my Health Ins **-OR-** ☐ Wait for Settlement	☐ WA LNI **-OR-** ☐ Self Insured Worker Comp

ASSIGNMENT, RELEASE, AND FINANCIAL RESPONSIBILITY

- **Certification and assignment.** I certify that I, and/or my dependent, have the coverage or claim listed on this form. I assign directly to Valente Chiropractic PLLC, its treating providers, and/or its assignees all insurance, claim, and other benefits payable for services rendered. I request that payment be made directly to Valente Chiropractic PLLC to the extent allowed by the applicable plan, policy, or law.
- **Financial responsibility.** I understand that I am financially responsible for all charges not paid by insurance or another payer, including any deductibles, co-payments, co-insurance, non-covered services, denied claims, or amounts that exceed available benefits.
- **Release/use of information for claims and payment.** I authorize Valente Chiropractic PLLC to use and disclose the minimum necessary medical, billing, and claim information to insurance companies, claim administrators, attorneys, and their agents as needed to verify benefits, submit and process claims, coordinate benefits, obtain payment, pursue appeals, and determine benefits payable for related services.
- **Signature on file.** I authorize Valente Chiropractic PLLC to use my signature on file for Box 12 and Box 13 of paper or electronic health insurance claim forms, including authorization to release information necessary to process claims and to direct payment of medical benefits to Valente Chiropractic PLLC.
- **UCC / lien notice.** To the extent permitted by applicable law, I understand that Valente Chiropractic PLLC may file a UCC financing statement, lien, or other notice to seek direct payment from the listed insurance companies or claim payers. Such filing may be searchable as a public record and may include the minimum necessary information, such as my name, address, claim number, amount owed, payer name/address, and this assignment/release.
- **Changes in coverage or claim status.** I understand that if I open or re-open a claim, change insurance, or my coverage changes, I may need to complete a new assignment and release form.

SIGNATURE

By signing below, I agree to the terms above. If signing for the patient, I confirm that I have authority to act as the patient's parent, guardian, or personal representative.

Signature: _____ Date: _____

Printed Name: _____ Relationship/Authority, if not patient: _____

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Informed Consent to Chiropractic, Massage, Manual Therapy & Related Care

Patient Name: _____ Date of Birth: _____

Nature of Care

Depending on your condition, examination findings, provider judgment, and your preferences, care may include one or more of the following:

- Chiropractic examination, orthopedic/neurologic testing, range-of-motion testing, posture or movement assessment, diagnostic x-rays, and other clinical evaluation.
- Chiropractic adjustments or manipulation using hands, instruments, tables, or other methods to apply controlled force to joints and related tissues.
- Massage therapy, soft-tissue therapy, trigger point therapy, stretching, or other manual therapy.
- Therapeutic exercise, rehabilitation, home-care instruction, activity modification, ergonomic advice, heat, cold, traction, taping, low-level laser/light therapy, or other conservative supportive procedures.

Chiropractic adjustments are intended to improve joint mobility, function, comfort, and/or related musculoskeletal symptoms.

Massage and manual therapy are intended to address muscles, connective tissue, movement, relaxation, pain, tension, and functional limitations through therapeutic manipulation or pressure of soft tissue. You may ask for lighter or deeper pressure, request a change in technique, decline treatment of any area, or stop the session at any time. Appropriate draping will be used when a patient is disrobed.

Possible Benefits

Possible benefits may include reduced pain, improved mobility, improved function, reduced muscle tension, improved tolerance for daily activities, and better understanding of your condition and self-care options. No specific result is guaranteed. If your provider believes your condition requires additional evaluation or care outside our clinic's scope, you may be referred to another health care provider.

Possible Risks and Side Effects

Most patients tolerate chiropractic, massage, and related conservative care well, but side effects and complications can occur. Common temporary effects may include soreness, stiffness, tenderness, fatigue, bruising, headache, dizziness, or a temporary increase in symptoms. Treatment may also irritate or aggravate an existing condition. Less common risks include muscle strain, ligament sprain, joint irritation, rib or other fracture, disc irritation, nerve irritation, radiating pain, numbness, tingling, or weakness, especially in patients with osteoporosis, fragile bones, cancer, trauma, long-term steroid use, or other risk factors. Massage, taping, lotions, oils, topical products, heat, cold, exercise, stretching, traction, positioning, or other therapies may cause skin irritation, allergic reaction, discomfort, dizziness, burns, or symptom aggravation. **X-rays, if taken, involve radiation exposure; please tell us if you are pregnant, may be pregnant, or are trying to become pregnant before any x-rays are taken.**

Serious complications from chiropractic manipulation are considered rare but may include fracture, worsening of a disc condition, nerve injury, stroke, arterial injury/dissection, or other serious injury. Neck manipulation has been associated in rare cases with stroke or vascular injury. **Please tell your provider immediately about unusual symptoms before, during, or after treatment.**

Alternatives to Care

Alternatives may include no treatment, self-care, exercise, rest, medication, physical therapy, medical evaluation, imaging, injections, surgery, or consultation with another health care provider. You may seek a second opinion at any time.

Consent

I have read this form, or it has been explained to me. I understand the general nature of the care, possible benefits, possible risks, alternatives, and the option of no treatment. I have had the opportunity to ask questions. I understand that I may refuse or stop any treatment at any time.

I consent to chiropractic care, massage therapy, manual therapy, therapeutic exercise, and related conservative care provided by Valente Chiropractic PLLC / its providers, unless I withdraw consent. If a materially different treatment or new condition involves different material risks, my provider will discuss those with me.

Signature: _____ Date: _____

Printed Name: _____ Relationship/Authority, if not patient: _____

Patient Acknowledgments, Financial Policy & Communication Permissions

Patient Name: _____ Date of Birth: _____

Financial Policy Acknowledgment

I understand that Valente Chiropractic PLLC will bill insurance or other payers when applicable and when the clinic has the information needed to do so. A quote or verification of benefits is only an estimate and does not guarantee payment, coverage, eligibility, or the amount my plan may pay.

I understand that I may be financially responsible for charges not paid by insurance or another payer, including deductibles, co-payments, co-insurance, non-covered services, denied claims, or amounts that exceed available benefits, except where prohibited by law, payer contract, or program rules.

I understand that Valente Chiropractic PLLC's full financial policy and standard fee schedule are available upon request. If I am uninsured or choose not to use insurance, I understand that I have the right to receive a Good Faith Estimate of expected charges for scheduled services or upon request.

Massage Appointment Policy

Massage appointments require reserved time with a massage therapist. If you need to cancel your appointment, please provide at least **24 hours' notice** so that another patient may receive care.

The following fees may apply in the event of a no-show, late cancellation, or late arrival:

Situation	Fee
No-show or cancellation with less than 24 hours' notice	**$50**
After more than 3 massage no-shows or late cancellations	**$70**
Arrival more than 15 minutes late	**$12.50***

*Late-arrival appointments may be shortened, rescheduled, or treated as a late cancellation.

Cancellations made at least 24 hours in advance are not charged a cancellation fee.
These fees are not billed to insurance and are the patient's responsibility unless prohibited by law, payer contract, or program rules.

HIPAA Notice of Privacy Practices Acknowledgment

I acknowledge that I have received or been offered Valente Chiropractic PLLC's Notice of Privacy Practices. I understand that the Notice explains how my health information may be used and disclosed, my privacy rights, and Valente Chiropractic PLLC's legal duties regarding my health information. I understand that I may request a paper copy of the Notice at any time and that the Notice is also available on the clinic's website at **https://spokanechiropractic.com/hipaa-npp**.

Permission to Discuss Information with Someone I Trust

I authorize Valente Chiropractic PLLC to discuss the categories of information checked below with the person or people I list. This permission allows discussion only as reasonably related to my care, scheduling, billing, payment, or account. I understand that I may revoke or change this permission at any time by notifying Valente Chiropractic PLLC in writing.

Relationship	Yes, Health/care Info	Yes, Billing/payment info	Yes, Appointment scheduling
Spouse: _____	☐	☐	☐
Parent/s or Guardian/s: _____	☐	☐	☐
Other: _____ Indicate Relationship: _____	☐	☐	☐

Signature

By signing below, I acknowledge the financial and massage appointment policies, confirm receipt or offer of the HIPAA Notice of Privacy Practices, and authorize the communication permissions selected above.

Signature: _____ Date: _____

Printed Name: _____ Relationship/Authority, if not patient: _____