Confidential Intake Form

All information you supply is confidential. We comply with all federal privacy standards.

Reason for visit (mark circle)

○ Work Injury -> Date of Injury (DOI): _____ Claim #: _____

○ Auto Injury -> Date of Injury (DOI): _____ Claim #: _____

○ Other (you will describe below)

_____ _____

Today's Date (mm/dd/yyyy) Who referred you/how did you find out about us?

Previous chiropractic, physical therapy, acupuncture or naturopathic care? ○ Yes ○ No _____

Date of last visit (approx)

_____ _____ _____ _____

Your full name Preferred Name Birth date (mm/dd/yyyy) Age

Gender (for insurance) ○ Male ○ Female ○ Single ○ Married ○ Divorced ○ Widowed ○ Separated

Gender (if applicable) ○ M2F ○ F2M Marital Status

_____ _____ _____ _____

Spouse's Name Child's name and age Child's name and age Child's name and age

_____ _____

Mailing address E-mail address

_____ _____ _____ _____

City State/Province ZIP/Postal Code Cell phone ○ OK to leave Voicemail?

_____ _____ _____

Emergency contact name Relationship Telephone

Employment Details

_____ _____ _____

Your occupation Your employer Work Telephone

_____ _____ _____ _____

Work address City State/Province ZIP/Postal Code

Family (PCP) and/or Specialist Doctor (if applicable)

_____ _____ _____ _____

Primary care physician (Family doctor) Clinic Telephone Fax

_____ _____ _____ _____

Specialist Clinic Telephone Fax

**If you would prefer us to NOT communicate with your PCP regarding care, mark "No" and initial: ○ No Initials: _____

_____ _____

Preferred Pharmacy Pharmacy Telephone

_____

Pharmacy Address

Insurance Information

_____ ____ /____ /_____ _____

Insured's name Insured's date of birth Insured's employer

_____ ____ /____ /_____ _____

Primary Policy Holder Primary's date of birth Relation to Insured

_____ _____ _____

Insurance company Member ID # (include alpha prefix) Group #

_____ _____ _____ _____

Insurance company's address City State/Province ZIP/Postal Code

Current Health Concerns:

Date of onset Description Possible cause

1. _____

2. _____

3. _____

4. _____

Current Medications

Itemize all medications you are currently using or have used recently. Please include all over-the-counter medications / hormones.

Name of drug	Reason for use	Dose	Start date / end date	Prescribing doctor / self

Do you have a known drug allergy? ( ) No ( ) Yes (Specify)_____

Have you ever had a non-allergy reaction to a drug ( ) No ( ) Yes (Specify):_____

_____

Current Supplements

Please list all vitamins, minerals, herbs, and other natural products that you are currently using or have used recently.

Name of supplement	Reason for use	Dose	Start date / end date	Prescribing doctor / self

Have you ever had an adverse reaction to a supplement? ( ) No ( ) Yes (Please explain): _____

_____

Previous Treatment for Current Health Concerns

( ) Check here if No previous treatment.

Condition or diagnosis:_____

Name of Doctor/Hospital:_____

Address:_____

Date first seen:_____ Date last seen:_____

Tests/imaging done, including x-rays? _____

Test results: _____

Was the condition treated? _____

Results of treatment: ( ) Good ( ) Fair ( ) Poor

Please list other doctors seen for this/these condition(s): ( ) None

Name	Date	Testing/treatment
1.		
2.		
3.		
4.		

Health Maintenance Update

Current Primary Care Physician:_____Phone:_____

Clinic name:_____Last visit:_____

Address:_____City:_____ _State: _____Zip:_____

Additional Providers (Doctors and clinic name):

Doctor:_____Clinic: _____

Doctor:_____Clinic: _____

Doctor:_____Clinic: _____

Please indicate approximate dates and results of most recent exams and imaging:

Exam	Date	Physician	Results
Full Physical Exam			
Dental Exam			
Cholesterol Profile			
Urine Sample			
Blood Work			
Prostate Exam (M)			
PAP/Pelvic Exam (F)			
Mammogram (F, 40+)			
Bone Density (DEXA)			
Eye Exam			
Colonoscopy or Flexible Sigmoidoscopy			
Other			

Imaging Studies

Imaging	Date	Physician	Reason for Imaging	Results
CT				
MRI				
X-Ray				
ECG (EKG)				
EEG				

Hospitalizations and Surgeries

Type of Surgery	Date	Physician	Reason	Result(s)

Occupation: _____

Who do you turn to for support: _____

Sources of stress: _____

I share my home with: _____

Smoking Status (circle): Never/Past/Current - Number of cigarettes/packs per day: _____

Recreational Drug Use: _____

Medical History (check all that apply)

Cardiovascular
- ☐ Abnormal heart rhythm
- ☐ Blood clot
- ☐ Carotid artery disease
- ☐ Congestive heart failure
- ☐ Coronary artery disease
- ☐ Deep vein thrombosis (DVT)
- ☐ High colesterol
- ☐ Hypertension
- ☐ Heart attack (MI)
- ☐ Peripheral vascular disease
- ☐ Phlebitis
- ☐ Heart valve disease

Renal/Urinary
- ☐ Benign prostatic hypertrophy
- ☐ Urinary incontinence
- ☐ Infertility
- ☐ Chronic renal failure
- ☐ Endometriosis
- ☐ Bed Wetting
- ☐ Erectile dysfunction
- ☐ Glomerulonephritis
- ☐ Kidney Stones
- ☐ Frequent bladder infections

Pyschiatric
- ☐ Anxiety
- ☐ Anorexia nervosa
- ☐ Bipolar
- ☐ Bulimia
- ☐ Depression
- ☐ Obsessive Compulsive
- ☐ Schizophrenia

Other
- ☐ Cataract
- ☐ Glaucoma
- ☐ Overweight

Pulmonary
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD
- ☐ Croup
- ☐ Cystic fibrosis
- ☐ Pneumonia
- ☐ Pulmonary embolism
- ☐ Pulmonary hypertension
- ☐ Respiratory syncytial virus
- ☐ Sarcoidosis
- ☐ Sleep apnea
- ☐ Tuberculosis (TB)

Musculoskeletal
- ☐ Degenerative disc disease
- ☐ Chondromalacia patella
- ☐ Chronic pain
- ☐ Fibromyalgia
- ☐ Bone fractures
- ☐ Endometriosis
- ☐ Gout
- ☐ Juvenile rheumatoid arthiritis
- ☐ Osgood-Shlatter disease
- ☐ Rheumatoid arthritis
- ☐ Systemic lupus erythematosis
- ☐ Osteoarthritis

Neurological
- ☐ Alzheimer's Disease
- ☐ ADD/ADHD
- ☐ Autism
- ☐ Stroke
- ☐ Dementia
- ☐ Headaches
- ☐ Migraines
- ☐ Multiple sclerosis (MS)
- ☐ Myasthenia gravis
- ☐ Parkinson's
- ☐ Sensory neuropathy
- ☐ Seizures ☐ TIA's

Gastrointestinal
- ☐ Gall Stones
- ☐ Cirrhosis
- ☐ Colon polyps
- ☐ Crohn's disease
- ☐ Incontinence of feces
- ☐ GERD (heartburn)
- ☐ Hepatitis
- ☐ Irritable bowel syndrome (IBS)
- ☐ Pancreatitis
- ☐ Peptic ulcer disease
- ☐ Ulcerative colitis

Hematogolic/Dermatolgy
- ☐ Acne ☐ Exzema
- ☐ Chicken pox ☐ Psoriasis
- ☐ Thalassemia ☐ Allergies (seasonal)
- ☐ Iron deficiency anemia
- ☐ Hemolytic anemia
- ☐ Pernicious anemia
- ☐ Sickle cell disease
- ☐ Allergy/ Immune/ Skin
- ☐ Immune deficiency
- ☐ Ear infections (frequent)
- ☐ Sinusitis (frequent)

Endocrine
- ☐ Diabetes
- ☐ Hypothyroid (low)
- ☐ Hyperthyroid (high)
- ☐ Grave's disease
- ☐ Hashimotos
- ☐ Other: _____

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Assignment of Health Plan Benefits and Rights as well as an appointment and/or designation as my personal representative and an ERISA/PPACA Representative and beneficiary:

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Vida Integrated Health as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been* or *will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy (ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider*. A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

_____ _____

Patient Signature Date

_____

Patient Name

© Informed Consent

I, _____, hereby authorize the naturopathic doctors, Medical doctors and nurse practitioners at any Vida Integrated Health clinic to perform or refer for the following specific procedures as necessary to facilitate my diagnosis and treatment (as stated under WA state RCW 18.36A.040):

- **Common Diagnostic procedures:** e.g., venipuncture, Pap smears, radiology, laboratory, X-ray.
- **Minor office procedures:** e.g., dressing a wound, ear cleansing, suturing, nasal specific, nasal sympatico.
- **Medicinal use of nutrition and food science:** e.g., therapeutic nutrition, nutritional supplementation, and intramuscular vitamin & herbal injections.
- **Botanical medicine:** botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, plasters, or suppositories.
- **Homeopathic medicine:** the use of highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's own innate healing responses.
- **Hydrotherapy:** e.g., constitutional hydrotherapy treatments with electrostimulation, contrast baths.
- **Physical medicine:** e.g., ultrasound, naturopathic adjustments, Craniosacral therapy, Visceral Manipulation, Low Level Laser treatment, magnet therapy.
- **Pharmaceutical medicine:** e.g., prescription of drugs listed on the Washington State naturopathic formulary.
- **Lifestyle counseling and hygiene:** e.g., diet therapy, Ayurvedic diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction, and balancing of work and social activities.
- **Psychological counseling techniques:** Emotional Freedom Technique (EFT), SomatoEmotional Release, Emotion Code Therapy, Motivational Interviewing, CBT, Biofeedback
- **Contraception and Contraceptive Devices:** recommendation, prescription, and management.
- **Immunizations:** age-appropriate immunizations for children and adults.

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

Patient Signature _____ Date _____

Patient Name _____

To be completed by patient's representative if patient is a minor or physically or legally incapacitated

Representative Signature _____ Date _____

Representative Name _____

AUTHORIZATION TO REQUEST MEDICAL HEALTH INFORMATION

I understand and authorize any Vida Integrated Health clinic to request health information regarding my condition(s) while under treatment at Vida Integrated Health. Vida Integrated Health may request any of the following, as long as it pertains to the treatment and care rendered at Vida Integrated Health, from the entities that I disclose.

Records of medical history.
- Examinations.
- Consultations.
- X-Ray reports.
- Laboratory studies.
- Operative and pathology reports.
- Physicians' and nurses' notes.
- Hospital records.
- Diagnoses.
- Prescription or treatment information relating to any disease, injury or other physical condition.

This authorization can be withdrawn by me at any time.

_____ _____
Patient Signature Date

_____
Patient Name

Notice of privacy practices acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations, such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed, to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Signature _____ Date: _____

Patient Name _____

Representative/Gaurdian Signature _____ Date: _____

Representative/Guardian Name _____

Office use only

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so, as documented below:

Date:

Initials:

Reason:

Vida Integrated Health-Office Policy Agreement: (please initial in box next to each section)

- ☐ As a courtesy to our patients we check your insurance benefits. The insurance information we obtain is given to us by your insurance company and is a quote of benefits and **NOT** a guarantee of payment or coverage. We do our best to receive correct information, but we have been **misquoted**. If you wish to know your benefits right away or know exactly what you will be responsible for, we encourage you to call the customer service number on the back of your insurance card.

- ☐ All insurance visit limits and dollar limits are YOUR responsibility to keep track of and monitor. If dates of service are denied for lack of coverage, denied for medical necessity or denied for going over your allowed visits, you are responsible for the balance.

- ☐ All co-payments and/or co-insurance portions **due** at the time of your appointment.

- ☐ Our Chiropractors at Vida use multiple modalities during their treatment. These services may include: traction, K-Laser therapy, myofascial release, stretching, kinesio-taping, balance training, graston, cuppling, active release technique, manual therapy, and therapeutic exercises. These services are often considered physical therapy codes and may be combined with your Physical Therapy benefits; therefore could take a visit away from that benefit and may also be subject to the same benefit level of physical therapy. This falls within the scope of a licensed chiropractor.

- ☐ Our Acupuncturists at Vida use multiple modalities during their treatment. These services may include: manual therapy, cupping and infra-red light therapy. These services are often considered physical therapy codes and may be combined with your Physical Therapy benefits; therefore could take a visit away from that benefit and may also be subject to the same benefit level of physical therapy. This falls within the scope of a licensed acupuncturist.

- ☐ By giving us a copy of your insurance card, we assume you want Vida Integrated Health to bill your health insurance for services rendered at our clinic. If you do not wish to bill insurance, it is **your** responsibility to let us know prior to your appointment. If your insurance changes or terms at any time and you have not notified us, you are responsible for any balances accrued as often pre-authorization is required by your insurance prior to your appointment.

- ☐ If you have a deductible, it is our policy to collect the following amounts that will go towards meeting that deductible, this is NOT the exact amount owing, this amount is a payment towards that deductible:
    - $85 each Chiropractic visit
    - $125 each Physical therapy visit
    - $60 each Massage
    - $70 Acupuncture visit
    - $120 Naturopathic visit

- ☐ **Cancellation policy:** We require 24 hours' notice if you are unable to keep your appointment for any reason. Any changes made less than 24 hours before your appointment time will incur an $85 charge. **No exceptions**.

By signing this form, you understand that you are personally and financially responsible for any remaining balances not covered by your insurance company, as well as any charges that incur based on the policies above.

_____ _____

Patient Signature Date

_____

Patient Name

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions on relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to the requested restriction.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

Patient Copy