McCann Family Chiropractic

About the Patient

Name_____

Address_____

City_____ State____ Zip_____

Home Phone_____ Birth date_____

Cell Phone_____ Social Sec. #_____

Email Address: _____

Would you like appointment reminders: Text or Email

Cell Phone Provider: _____

Age_____ Gender _____M _____F Number of Children_____

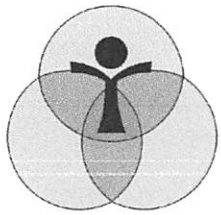
Status: Married Single Divorced Separated Widowed

Employer _____

Type of work_____

Work Address_____

Insurance Company _____ Policy Holder _____



Emergency Contact

Name of friend or relative

_____

Relationship to patient

_____

Home Phone

_____

Cell Phone

_____

Experience With Chiropractic

Who referred you to this office?_____

Have you been adjusted by a chiropractor before? ___Yes ___No

Reason for those visits?_____

Doctor's Name_____

Approximate Date of Last Visit_____

Has any *adult* in your family seen a chiropractor? ___Yes ___No

Has any *child* in your family seen a chiropractor? ___Yes ___No

Health Habits

Do you smoke? ___No ___Yes

Do you drink coffee? ___No ___Yes

Do you exercise regularly?

___No ___Moderate ___Daily

Do you wear?

___Heel Lifts ___Orthotics

Awareness of Chiropractic Principles

Were you aware that:

- ...Doctors of Chiropractic work with the nervous system? ☐ Yes ☐ No
- ...the nervous system controls all bodily functions? ☐ Yes ☐ No
- ...if Chiropractic care starts at birth, you can achieve a higher level of *health throughout life*? ☐ Yes ☐ No

Primary Complaints

If you are currently experiencing symptoms or have experienced any of these symptoms in the last 8 weeks please circle all that apply

Neck Pain : Mid-Back Pain : Low Back Pain : Headache : Shoulder Pain

Arm(s): Tingling / Pain / Numbness (Circle) Right or Left (Circle)

Leg(s): Tingling / Pain / Numbness (Circle) Right or Left (Circle)

Other: (Please Include All Other Health Concerns)_____

_____

2) When Did You First Experience This/These Problems? _____

3) Due To A Particular Incident? (Explain) _____

_____

4) Is The Problem(s) Getting (Please Circle) Worse Same Better

5) What Relieves The Problem? (What Have You Tried For Relief?) _____

_____

6) Is The Problem(s) Worse In The (Please Circle)

Morning : Afternoon : Evening : Same All Day : Varies

7) Does The Pain Radiate To Any Part Of Your Body? (Please Circle)

Arms : Legs : Buttocks : Chest : Shoulders : Head : Fingers : Toes

8) How Often Do You Experience This Pain/Problem? (Please Circle)

1 X/Day : 5X/Day : 10 X/Day : Constant : Varies

Other_____

9) Have You Had Other Treatment For This Condition? Y N

Dr.'s Name(s)_____

Type Of Treatment_____ Results (please Circle) Positive : Negative : No Change

10) Have You Had Any Previous Injuries To The Areas You Mentioned Above? Y N

When Did This Occur?_____

Were You Treated For The Injury?_____

If So, Where?_____

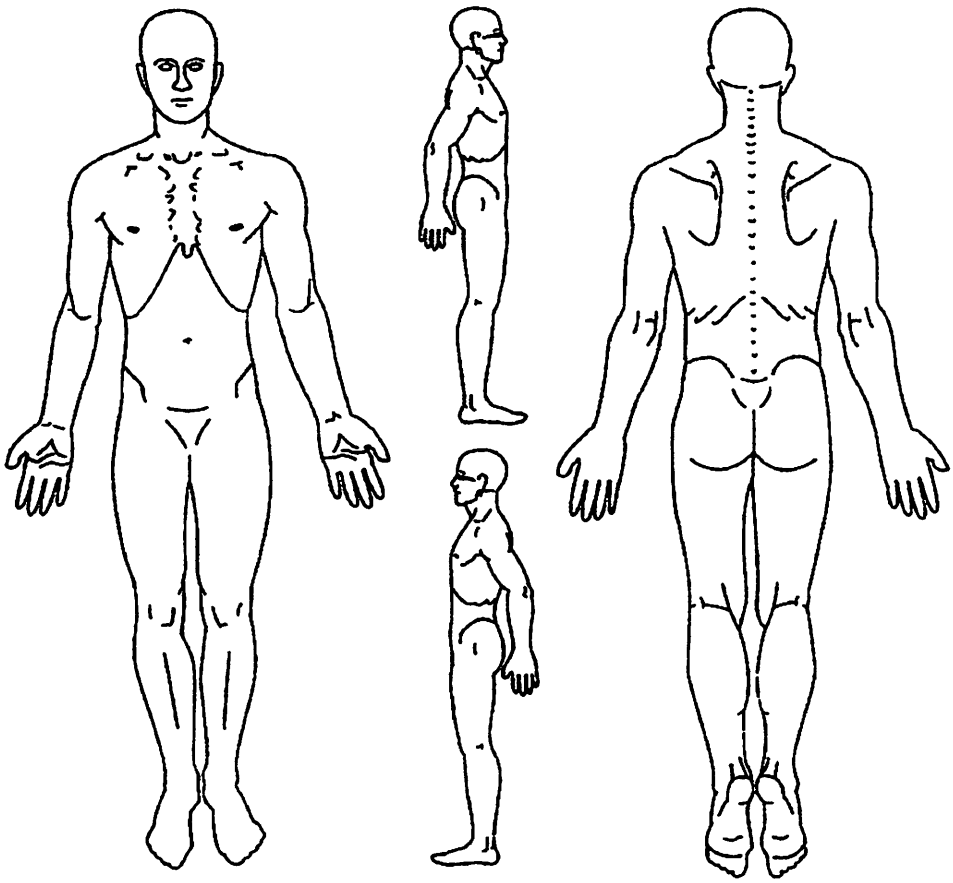
_____ _____

Patient's Signature: Date:

Females only: Is There Any Chance That You Are Or May Be Pregnant Yes No

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

D = Dull	**S** = Stabbing/Cutting
B = Burning	**T** = Tingling (Pins & Needles)
N = Numb	**C** = Cramping



On the scales below, please draw a vertical line representing your pain or discomfort:

Rate the pain you have right **now:**

No Pain — Unbearable Pain

Rate your pain at its **best** in the past week:

No Pain — Unbearable Pain

Rate your **average** pain in the past week:

No Pain — Unbearable Pain

Rate your **worst** pain in the past week:

No Pain — Unbearable Pain

Name_____ Date_____

Health Conditions

Please check each of the diseases or conditions that the patient has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

___Headaches
___Heart Surgery/ Pacemaker
___Sinus Problems
___Dizziness
___Loss of Sleep
___Digestive Problems
___Difficulty Breathing
___Asthma
___Numbness in Limbs
___Alcohol/Drug Abuse
___Visual Disturbances
___Heart Defect / Murmur
___Kidney Problems
___Hepatitis
___Cancer
___High/Low Blood Pressure
___Anemia
___Rheumatic Fever
___Psychiatric Problems
___Arthritis
___Chronic Fatigue
___Difficulty Urinating
___Shingles
___Heart Attack/Stroke
___Ulcers
___Venereal Disease
___Chemotherapy
___HIV/Aids
___Tuberculosis
___Diabetes
___Thyroid Problems
___Drop Attacks (Fainting spells)

For Women

Are You Pregnant?	___Yes	___No
Are You Nursing?	___Yes	___No
Are You Taking Birth Control?	___Yes	___No
Do You Experience Painful Periods?	___Yes	___No
Do You Have Irregular Cycles?	___Yes	___No
Do You Have Breast Implants?	___Yes	___No

Medications

___Anti Inflammatories
___Pain Killers
___Muscle Relaxers
___Blood Pressure Medicine
___Insulin
___Blood Thinners
___Anxiety / Depression Meds
___ Other
_____
_____

Goals For My Care

People see Chiropractors for a variety of reasons. Some go for relief of pain and some to correct the cause of pain along with whatever may be malfunctioning in their bodies as a result of these problems. The Doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- ☐ Relief Care - Symptomatic relief of pain or discomfort.
- ☐ Corrective Care - Correcting and relieving the **cause** of the problem as well as the symptoms.
- ☐ I want the Doctor to select the type of care appropriate for my condition.

Name _____ Date_____

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

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.

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

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae 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.

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 that 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 expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____, have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis._____ _____
(signature) *(date)*

X-ray Consent
and Statement of Non-pregnancy

X-ray studies are one way of looking at the structure of the human frame. Doctors of Chiropractic utilize X-ray analysis as a valuable tool to see if the body is properly balanced and if vertebrae and other skeletal structures are in proper alignment. This helps us determine the structural integrity of your skeletal system.

Long-term spinal nerve stress (vertebral subluxation) may cause an inflammatory condition of the bone and related structures and may result in premature aging called spinal degeneration (also known as osteo-arthritis). An X-ray can tell us if you have this condition.

X-rays are a form of electromagnetic radiation and may have adverse effects on body tissue, especially rapidly dividing cells. For this reason, we limit X-ray exposure as much as possible and we only perform x-ray studies when it is clinically necessary.

I hereby consent to any necessary chiropractic X-ray studies (that the doctor will inform me of during the examination). This will allow the doctor to fully determine the condition of my spine.

Signature:_____ Date:_____

For Women Only:

Due to the chance of adverse effects on rapidly dividing cells and body tissue, X-rays have been shown to have negative effects on unborn children. Therefore, X-ray studies on pregnant women should only be done in an emergency. In signing below, I state to the best of my knowledge, there is no pregnancy, confirmed or suspected at this time.

Signature:_____ Date:_____

McCann Family Chiropractic

11605 State Avenue, Suite 111, Marysville, WA 98271
360-657-7183

McCann Family Chiropractic Office Financial Policy

Welcome to McCann Family Chiropractic. Our goal is to provide you with excellent service, including transparent financial policies and procedures. Please read this policy carefully and do not hesitate to ask a member of our team if you have any questions.

Primary Contact: Billing Coordinator, Stephanie Lofton, backdesk@mfcwellness.com

Insurance Coverage

Your insurance policy is an agreement between you and your insurer, not between your insurer and this office. Like all types of care, coverage for chiropractic and massage services varies from insurer to insurer and plan to plan. Our office will call your insurer to verify your benefits, however, we are not responsible for your insurer's final payment and benefit determinations.

It is your responsibility to understand your benefit plan. You are responsible for any and all deductibles, co-payments, and co-insurances. Co-payments and co-insurance payments are due at the time of service. Deductible amounts are due immediately upon receipt of an Explanation of Benefits. You may keep a credit card on file for payment of services. Your credit card information will always be stored securely and this will help to ensure your account is current and not subject to late fees.

Additionally, not all services are covered by insurance. We will make every attempt to inform you of non-covered services so that you can make an informed decision; however, **you are ultimately responsible for all services rendered**.

Please inform us of any insurance changes as soon as you are aware of them, including auto accidents or work injuries.

Time Of Service Discount

If our providers do not participate in your insurance plan, payment in full is expected from you at the time of your office visit. If you do not have insurance or we do not participate in your insurance plan, you may be entitled to a 20% time of service discount ("TOSD"). This discount reflects a reduction in our costs for not having to bill you or your insurance company. In order to be eligible to receive this discount, you **MUST** pay at the time of service and no balance may be outstanding on your account.

Wellness care and supplements are not covered by insurance and are not billed to third parties. Therefore, no TOSD applies.

Care Plan

You may be offered an estimated care plan with a monthly payment option. Care plans require a credit or debit card to be kept on file for monthly auto-payment. Further details regarding care plans will be discussed if this option applies to you.

Cancellation Policy

Please call our office to cancel your appointment by 8 AM the business day prior to your appointment. (Business day is Monday to Friday, regardless of whether the office is open for chiropractic or massage appointments over the weekend). There is no cancellation fee for chiropractic appointments, however, we greatly appreciate the courtesy of your notice.

Massage cancellations that do not adhere to the above policy are billed at $50. This fee is not billable to any insurance company, including work or auto injury, and is your direct responsibility.

Past Due Accounts

Any account with a balance of greater than 30 days may be charged a service fee of 12% per year, compounded monthly. Any account where no payment has been received for over 60 days, and has not made payment arrangements with the Billing Coordinator may be sent to a third party collections agency. Any additional collection fees will be the responsibility of the patient.

NSF checks or rejected credit card payment will be charged a service fee of $25 per occurrence.

Patient Name(s): _____

_____ _____
Responsible Party's Name Relationship

_____ _____
Responsible Party's Signature Date

PATIENT ACKNOWLEDGMENT

I acknowledge I have received and read the Notice of Privacy Practices.

_____ _____

Name Date

_____

Signature

_____

Relationship to Patient (if patient is a minor or not able to sign)

McCann Family Chiropractic

11605 State Avenue, Suite 111
Marysville, WA 98271

360-657-7183 p
360-657-7188 f

Date:_____

Patient Messaging Consent

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my healthcare provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, or other communications.

I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events.

I consent to receiving multiple messages per day from the automated outreach and messaging system, when necessary.

_____ _____

Patient name

Patient Signature
(Parent/Guardian if patient under 18 years of age)

Text / Email (circle one and fill in space below)

Cell number: _____ Email: _____

If Text is preferred, cell phone provider: _____

Receive reminder how soon before appointment? (circle one)

1 hour
4 hours
1 day

McCann Family Chiropractic

11605 State Avenue, Suite 111, Marysville, WA 98271

360-657-7183

McCann Family Chiropractic: COVID-19 Policies & Procedures Update

November 17, 2020

Our goal is to provide you with excellent service, including ensuring your safety during the ongoing COVID-19 pandemic.

Masks

A cloth face covering is required to be worn during the entirety of your office visit. We cannot make exceptions due to philosophical objections. We will provide you with a mask if you do not have one.

During your visit, you may need to lower your mask when:

1. Taking an upper neck x-ray. Dr. Matt or our Exam Technician will advise you when to remove your mask.
2. Lying face down on the adjusting table. Many patients find it difficult to breathe when a mask is on while lying face down. You may lower your mask during this time. Please ensure your mask is on during the rest of your adjustment.

What if I have a valid medical exemption?

If you have a ***valid medical exemption***, our strong preference is that you wear a face shield. In this case, you may proceed with your appointment as usual.

If you are unable to wear a face shield, **please call the front office when you arrive**. Our front desk CAs will advise you of other procedures and you will be taken immediately back to your appointment room, when it is ready. Please do not enter before your room is ready for you. All common areas, including lobby, should not be used by those who are unable to wear a mask or face shield.

Social Distancing

Please maintain 6 feet social distancing when in our office. Due to this requirement, the front lobby area is limited to a total of ***four*** patients at any time (this includes people from the same family).

- If there are more than 4 people in the lobby, please call the office to let us know you've arrived and wait in your car.
- If you are more than 10 minutes early to your appointment, please call when you arrive so we can be sure we can accommodate you in the lobby
- Please do not bring extra guests to your appointments. A parent may accompany a minor child.
- Please do not ***linger*** in the front desk area after your adjustment. We will take care of payment, scheduling, and any other needs on your way in. Please exit the facility directly after your treatment is complete.

Wellness Based Clinic

We are a symptom free office! No employees, patients, or others may have any symptoms of COVID-19 while in our facility. Please do not enter if:

- You or any member of your household have been advised by a medical professional to quarantine due to COVID-19 illness or exposure.
- You are awaiting COVID-19 test results.
- You or any member of your household are experiencing fever, sore throat, cough, shortness of breath, loss of smell or taste, or any other respiratory symptoms.

Other Procedures

1. Upon arrival, we will check your temperature.
2. Upon arrival, please sanitize your hands.
3. All pens and stylus' used for check-in are sanitized after each use. All high touch areas are sanitized frequently throughout the day. All treatment areas are sanitized after each appointment.
4. Hand sanitizer is available throughout the facility.
5. We have installed high quality HEPA air filters throughout the office to improve air quality and provide extra safety.

Thank you for helping us keep our facility safe for all!

PATIENT ACKNOWLEDGMENT

I acknowledge that I have received and read McCann Family Chiropractic's Notice of COVID-19 Policies and Procedures, dated November 17, 2020

_____ _____

Name Date

_____

Signature

_____

Relationship to Patient (if patient is a minor or not able to sign)