McCann Family Chiropractic

Tel: (360) 657-7183
Fax: (360) 657-7188
11605 State Ave, Suite 111
Marysville, WA 98271
E-mail: frontdesk@mfcwellness.com
www.mfcwellness.com

CONFIDENTIAL PATIENT INFORMATION

Personal Information

Full name:	**Date:**
Address: Street City State Zip	
Home phone:	**Work phone:**
Cell phone:	**Email address:**
Best time/way to contact you:	
Date of birth:	**Age:**
Number of children:	**Pregnant?** Yes ☐ No ☐
Height:	**Weight:**
Driver's license number:	
Marital status: M S W D	**Spouse/guardian name:**
Occupation:	
Employer's name & city:	
Spouse's Occupation/Employer:	
Name of person responsible for account:	
Do you have insurance that covers Chiropractic care? Yes ☐ No ☐	**Do you have Medicare coverage?** Yes ☐ No ☐
If yes, Name of Insurance Company:	
Insurance Policy number:	**Insurance Company phone number:**
Insurance Company address:	

Whom may we thank for referring you or where did you hear about us?

_____

Addressing What Brought You To This Office:

If you have no symptoms or complaints and are here for Optimal Health & Wellness Services, please skip to the ***"General Health History"****.*

Health Concerns

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain/symptom present
1.					
2.					
3.					
4.					

ONSET
Did your symptoms start suddenly or progressively? _____

What were you doing when your symptoms started?_____

Since the problem started is it: About the same? ☐ Getting better? ☐ Getting worse? ☐

_____

Provocation/Palliation
What makes it worse? _____

_____

_____

What makes it better? _____

_____

_____

Quality
How would you describe your symptoms? Dull? Sharp? Ache? Etc.

_____

_____

Region/Radiation
Where do you feel the symptoms? Does it radiate? _____

_____

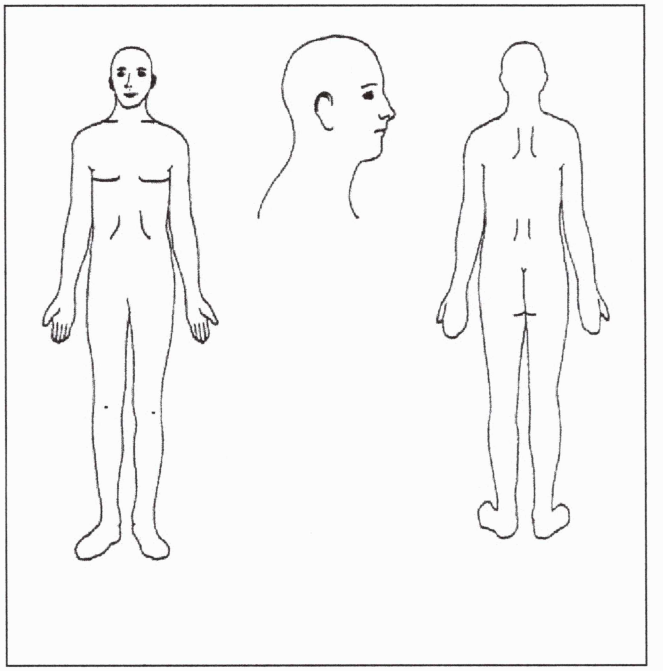
_____

What have you done for this condition? Was it of benefit? _____

_____

_____

Please mark on the diagram below where your problems are located
P = Sharp pain **A** = Ache
T = Tightness **N** = Numbness
W = Weakness



I do (do not) have a family history of this or similar symptoms (Please explain):

_____

_____

Other doctors you have seen for this condition:

Chiropractor	☐
Naturopath	☐
Medical Doctor	☐
Dentist	☐
Other (please describe)	☐

Doctor's details:

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Have you been "forced" or "felt the need" to make any "positive" changes in your life due to this pain, illness, condition, etc? (i.e., eat better, less alcohol or drugs, meditate or breathe more, less destructive sports, activities, etc.) If so, what?

_____

_____

Is this condition interfering with any of the following:

Work ☐	Sleep ☐	Daily routine ☐	Sports/exercise ☐	Other ☐ (please explain):

General Health History

Oftentimes, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!

Have you had any surgery? (Please include all surgery)

1. Type:	When?	Doctor
2. Type:	When?	Doctor
3. Type:	When?	Doctor
4. Type:	When?	Doctor

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems).

1. Type:	When?	Hospitalized? Yes ☐ No ☐
2. Type:	When?	Hospitalized? Yes ☐ No ☐
3. Type:	When?	Hospitalized? Yes ☐ No ☐

Have you ever had x-rays taken?

Area of body:	When?	Where?

Do you wear orthotics or heel lifts? Yes ☐ No ☐

Current Medications and Supplements

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

_____

_____

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

_____

_____

Are you interested in knowing more about how your nutrition (food you eat) affects your overall health and well-being?	Yes ☐ No ☐ Maybe ☐
If dietary changes are indicated would you be willing to make changes in your diet?	Yes ☐ No ☐ Maybe ☐
Would you take whole food supplements if indicated?	Yes ☐ No ☐ Maybe ☐
If specific exercises or stretching would help would you consider adding them to your program?	Yes ☐ No ☐ Maybe ☐
If reducing stress would help you would you like to know ways to reduce stress?	Yes ☐ No ☐ Maybe ☐

Diet

Please circle any dietary selection that is appropriate for you, and grade according to the following scale:

D - Consume this daily | **FD** - Consume this a few times per day | **W** - Consume this weekly | **FW** - Consume this a few times per week
M - Consume this monthly | **FM** - Consume a few times per month (less than weekly) | **O** - Do not consume this

Alcohol	Eggs	Fasting	Artificial Sweetener
Tobacco	Fruit	Diet food	Weight Control Diet
Coffee	Beef	Refined Sugar	Raw Vegetables
Soda	Poultry	Fish	Whole Grains
Fried Foods	Organic foods	Seafood	Dairy
Cooked or canned vegetables			

The type of diet I usually follow is classified as: _____

Past Health History

Please mark the following conditions you may have had or have now (please mark "**-**" if you have had and "**+**" if you have it now):

☐ Alcoholism	☐ Allergy	☐ Anemia	☐ Arteriosclerosis	☐ Arthritis	☐ Asthma
☐ Back Pain	☐ Cancer	☐ Cold Sores	☐ Constipation	☐ Convulsions	☐ Depression
☐ Diabetes	☐ Diarrhea	☐ Eczema	☐ Emphysema	☐ Epilepsy	☐ Gall Bladder Problems
☐ Gout	☐ Headaches	☐ Heart Attack	☐ Heart Disease	☐ High Blood Pressure	☐ HIV (Aids)
☐ Irregular Periods	☐ Low Blood Sugar	☐ Malaria	☐ Measles	☐ Menstrual Cramps	☐ Migraines
☐ Miscarriage	☐Multiple Sclerosis	☐Mumps	☐ Neck Pain	☐ Nervousness	☐ Neuritis
☐ Pleurisy	☐ Pneumonia	☐ Polio	☐ Rheumatic Fever	☐ Ringing in ears	☐Sinus Problems
☐ Stroke	☐ Thyroid Problems	☐Tuberculosis	☐ Ulcers	☐ Venereal Disease	☐ Whooping Cough

Other (please explain) _____

_____

_____

Stressors

Because accumulation of stress affects our health and ability to heal, please list your top three stresses (you have ever had) in each category:

1. Physical stress (falls, accidents, work postures, sports etc.)
   a. _____
   b. _____
   c. _____

2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)
   a. _____
   b. _____
   c. _____

3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)
   a. _____
   b. _____
   c. _____

On a scale of 1-10 please grade your present levels of stress (including physical, bio-chemical and psychological or mental/emotional):

At work:	At home:	At play:

On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your:

Eating habits:	Exercise habits:	Sleep:	General health:	Mind set:

How do you grade your physical health?

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Getting better ☐	Getting worse ☐

How do you grade your emotional/mental health?

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Getting better ☐	Getting worse ☐

Is there anything else which may help to better understand you which has not been discussed?

_____
_____
_____
_____
_____

Why are you here at this point in time?

_____
_____
_____
_____
_____

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary.

I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Patient Name: _____ Date: _____

Signature: _____

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.

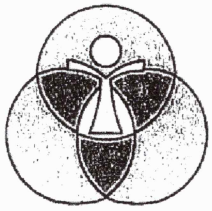
We do not offer to diagnose or treat any disease or condition other than vertebral subluxation.
However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we 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:_____

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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) _____

Rev. August 15, 2018

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11605 State Avenue, Suite 111
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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

Rev. June 14, 2018

Consent to Evaluate and Adjust a Minor

I, _____, being the parent or legal guardian of

_____ have read and fully understand the

terms of acceptance and hereby grant permission for my child to receive chiropractic

Care/ massage therapy, consisting of evaluation and adjustments (if necessary) and massage while I am not present.

Signature: _____ Date: _____