Vital
CHIROPRACTIC, PLLC
& Wellness Center

Terms of Acceptance

When a member of Vital Chiropractic Center seeks chiropractic health care and we accept a member 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 member understands 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 hand delivered forces to facilitate the body's correction of vertebral subluxation. Our Chiropractic method of correction is by specific adjustments to the spine.

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 of 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 advise, 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 is to eliminate a major interference to the expression of the nerve impulse. Our only method is the specific adjusting to correct vertebral subluxations.

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

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

I therefore accept Chiropractic care on this basis.

Signature _____ Date _____

New Member Information

Welcome to our office! Please complete all questions.

Name:_____ Date:_____

Address:_____ City:_____

State:_____ Zip:_____ Home Phone:_____ Work Phone:_____

Birth Date:_____ Age:_____ Social Security #:_____

Biological Sex: ☐ Male ☐ Female ☐ Intersex

Gender Identity: ☐ Male ☐ Female ☐ Non-Binary ☐ Other: _____

Marital Status: ☐ M ☐ W ☐ D ☐ S Spouse's Name:_____

Your Employer:_____ Occupation:_____

Children's Names and Ages:_____

E-mail address:_____

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications: Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment , to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

____ (Patient Initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing. The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is_____.

The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is_____.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Method of Payment for First Visit: ☐ Cash ☐ Check ☐ Credit Card ☐ Insurance

Reasons For Consulting Vital Chiropractic Center:

1. _____

2. _____

3. _____

4. _____

Who referred you to our office?_____

The human body is designed to be healthy. Throughout life, events occur which can limit your life and health expression. Your Nervous system, comprised of the Brain and Spinal Cord is the master control system of the body responsible for regulating and directing every single organ, gland, and tissue in the body 24 hours per day 365 days per year. Since birth we have been encountering stress in our every-day life that can cause interference to this vital system. This case history will uncover possible sources for Nervous System Interference which could limit your life and health expression.

Your Nervous System is susceptible to interference from the first day it is formed. After conception, the Nervous System is the first structure formed in the fetus. It's responsibility is to coordinate and direct the formation on an entire human being. Your growth in the womb and your birth experience are critical to the rest of your development, because they are events in which can be traumatic to the Nervous System decreasing ones life and health potential at the start of their life.

Please circle the best response

Pregnancy - *Did your mother?*

Smoke or drink alcohol? ☐ Yes ☐ No ☐ Unsure
Have a proper diet? ☐ Yes ☐ No ☐ Unsure
Exercise through her pregnancy? ☐ Yes ☐ No ☐ Unsure
Experience any falls and injuries during pregnancy? ☐ Yes ☐ No ☐ Unsure
Experience any physical and/or mental abuse? ☐ Yes ☐ No ☐ Unsure
Have any illnesses during pregnancy? ☐ Yes ☐ No ☐ Unsure
Take any prescription medication/OTC medication during pregnancy? ☐ Yes ☐ No ☐ Unsure
Have regular Nervous System/Chiropractic Check ups during pregnancy? ☐ Yes ☐ No ☐ Unsure

Birth History

Was the delivery long? Length:_____ ☐ Yes ☐ No ☐ Unsure
Was the delivery difficult? ☐ Yes ☐ No ☐ Unsure
List Difficulties:_____

Forceps or extraction devices used? ☐ Yes ☐ No ☐ Unsure
Caesarean? ☐ Yes ☐ No ☐ Unsure
Breech or Cephalic? ☐ Breech ☐ Cephalic ☐ Unsure
Home Birth? ☐ Yes ☐ No ☐ Unsure
Hospital Birth? ☐ Yes ☐ No ☐ Unsure
Mother given drugs during delivery? ☐ Yes ☐ No ☐ Unsure
What drugs?_____
Was labor induced? ☐ Yes ☐ No ☐ Unsure
Were you checked by a Chiropractor for Nervous System Interference? ☐ Yes ☐ No ☐ Unsure
Post labor difficulties? ☐ Yes ☐ No ☐ Unsure
If yes, please explain:_____

Growth & Development

Did you have regular spinal check-ups for Nervous System Interference? ☐ Yes ☐ No ☐ Unsure
Were you breastfed? ☐ Yes ☐ No ☐ Unsure
If Yes, How Long?_____
Childhood sickness? ☐ Yes ☐ No ☐ Unsure
Accidents? ☐ Yes ☐ No ☐ Unsure Explain:_____
Surgery? ☐ Yes ☐ No ☐ Unsure List:_____
Drugs/Medications? ☐ Yes ☐ No ☐ Unsure List:_____
Did you fall while learning to walk? ☐ Yes ☐ No ☐ Unsure
Did you rough house with siblings or friends? ☐ Yes ☐ No ☐ Unsure
Child Abuse? ☐ Yes ☐ No ☐ Unsure
Spanking / Pulling on ear, chin, arms or legs etc.. ☐ Yes ☐ No ☐ Unsure
Other traumas?_____

As we continue life we still encounter stress that can impact our Nervous System and cause interference. Lifestyle choices affect your level of Nervous System Interference. Nervous System Interference is caused emotional, physical and chemical stress.

Please circle the best response

Current Issues

Did/Do you smoke? ☐ Yes ☐ No How Much?_____ How Long?_____

Did/Do you drink alcohol? ☐ Yes ☐ No How Much?_____

Do you eat healthy foods? ☐ Yes ☐ No ☐ Unsure

Have you been in accidents? Explain:_____

Have you had surgery? ☐ Organs removed ☐ Organs replaced? List:_____

Drugs? ☐ Prescription ☐ Non-prescription? ☐ Yes ☐ No ☐ Unsure

Exercise regularly? Activities_____ Days per week _____

Do you sleep soundly? ☐ Yes ☐ No Hours per night?_____

Did/Do you have occupational stress? ☐ Yes ☐ No ☐ Unsure

Physical Stress? ☐ Yes ☐ No ☐ Unsure

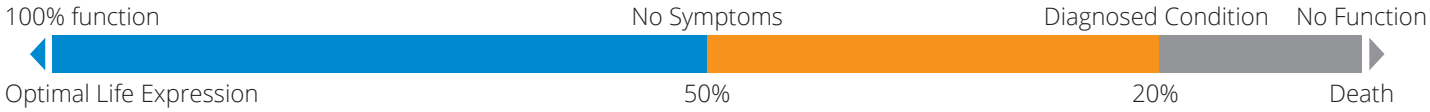
Mental Stress? ☐ Yes ☐ No ☐ Unsure

Sleep position: ☐ Back ☐ Stomach ☐ Side ☐ Other (explain)_____

Any other traumas, concerns or problems?_____

When an individual begins life with limited health and life expression as a result of Nervous System Interference, and continue to encounter thoughts, traumas, and toxins. After the body's function has been decreased for long periods of time the body is unable to run at it's best and is unable to carry out its responsibility of running all body functions. Eventually the body has to tell us about the injustice we are doing to it and talks to us through symptoms. The symptoms are collectively named by doctors as a dis- ease.

Wellness Scale



Please mark the wellness scale above with a circle where you feel you are currently and a star with where you want to be in the future.

How does your current condition affect your daily life?_____

How does it affect your family?_____

How has having this complaint changed your life?_____

How does having this complaint make you feel?_____

Do you have any other concerns?_____

The above information is true and accurate to the best of my knowledge.

Patient or Guardian Signature: _____ Date:_____

X-Ray Consent Form

The doctor has explained the purpose of the x-rays to be taken is to analyze the spine for vertebral subluxations and to determine the appropriateness of chiropractic spinal adjustments. If the doctor discovers a non-chiropractic "unusual finding" when reviewing the x-ray, I will be informed. I then must determine if I should seek the services of an additional health care provider for advice, diagnosis, or treatment for the unusual finding. I understand that seeking advice from another type of health care provider should not interfere with the subluxation corrective care provided by this office.

I fully understand the above and consent to chiropractic spinal x-rays.

Patient's Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the doctor and his/her associates of **Vital Chiropractic** have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual period:_____

Signature:_____ Date:_____

Parental Consent Form

I_____ give the doctors of **Vital Chiropractic**,
(Print Parent's Name)

Mount Vernon, WA permission to provide chiropractic care, including any necessary exams and adjustments,

to my child, _____.
(Print Childs Name)

Signature:_____ Date:_____

FORM-P-005

I consent to the use or disclosure of my protected health information by **Vital Chiropractic** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Vital Chiropractic**.

I understand that diagnosis or treatment of me by **Vital Chiropractic** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. **Vital Chiropractic** is not required to agree to the restrictions that I may request. However, if **Vital Chiropractic** agrees to a restriction that I request, the restriction is binding on **Vital Chiropractic** and **Vital Chiropractic**.

I have the right to revoke this consent, in writing, at any time, except to the extent that **Vital Chiropractic** or **Vital Chiropractic** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **Vital Chiropractic**'s Notice of Privacy Practices prior to signing this document.

The **Vital Chiropractic**'s Notice of Privacy Practices has been made available to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my care, payment of my bills or in the performance of health care operations of the **Vital Chiropractic**.

The Notice of Privacy Practices for **Vital Chiropractic** is also provided and displayed in the reception area along the north wall.

This Notice of Privacy Practices also describes my rights and the duties of **Vital Chiropractic** with respect to my protected health information.

Vital Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority

Financial Policies and Agreement

It is extremely important that we clarify our financial policies so there is no confusion about everyone's responsibilities and expectations when it comes to paying for care. Outlined below is our Financial Policies and Agreement.

THIRD PARTIES

If you have health insurance that we are IN-NETWORK with, were injured on the job, in an automobile accident or some other personal injury, you may have other options. In general, we expect payment of deductibles, co-payments and co-insurance at the time of each visit, or at the end of the week when multiple visits per week are occurring.

I (the client) am responsible for all co-payments, deductibles, and co-insurance as per the terms of my contract with my insurance carrier.

All co-payments must be paid at the time of service

I am responsible for obtaining any and all required referrals for service. I am responsible for all non-covered services. The office will do its best to inform me of any service that will not or may not be covered. However, I understand that benefits are not determined by my insurance carrier until after the claim is submitted; therefore, there is no guarantee of payment by my insurance carrier.

I am responsible for updating my health insurance information with the office any time the information changes, terminates, or new coverage begins. The office will submit my medical claims for me as per the terms of the contract with my insurance carrier. For insurances we are OUT OF NETWORK with we will not directly bill but we will supply our client with an itemized statement, or a "superbill", that they can directly submit to their insurance company.

The office is restricted to a "timely filing period." I understand that I must supply the office with my health insurance card in a timely fashion, so that the claim may be paid. Any claim unpaid because I did not supply the office with my health insurance information in a timely fashion is my responsibility and I agree to make payment

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY

I hereby authorize payment directly to the Provider. I understand that my insurance policy is a contract between myself and my insurance provider and that I am ultimately financially responsible for non-covered services. The Provider will file my insurance claim only as a courtesy.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the Provider to release any information required to process my claim.

Individual Consideration: If there is financial hardship associated with receiving care in our office, please understand that we have never refused any client due to their financial situation. We will however come to some agreement for payment of services that both parties can agree on.

BILLING

We have a payment at time of service policy however we understand that circumstances sometimes change. Outstanding balances will be billed monthly and considered past due 14 days after the invoice date. Balances beyond 45 days will be charged a billing fee of 5% per month, plus any legal or collection fees.

A check returned from our financial institution is subject to a returned check fee.

The current fee is $35.00 per return.

MISSED APPOINTMENTS

Vital Chiropractic, PLLC and Wellness Center is committed to providing all of our clients with exceptional care. We understand that situations arise in which you must cancel or reschedule your appointment.

We strive to help as many individuals and families to live their best life through wellness! When a client cancels or reschedules without giving enough notice, they prevent another client from being seen and reaching their wellness goals.

Please call us at 360-848-6755 by 1:00pm on the business day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 1:00 PM on Friday. If prior notification is not given you may be charged $30 for the missed appointment.

AGREEMENT

This is the entire financial agreement between Vital Chiropractic, PLLC and the patient below. I have read this agreement, understand it and agree with its provisions.

_____

Patient's Name Printed

_____

Patient Signature

_____

Guardian Signature if applicable

_____

Date Signed

You may revoke this authorization at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed. Your revocation request should be addressed to our office:

Vital Chiropractic, PLLC
600 N 4th Street
Mount Vernon, WA 98273

Submit Form