Bradbury Chiropractic Clinic

Dr. Timothy Bradbury
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Eastsound, WA 98245
360-224-6220

*** PATIENT INTAKE FORM***

Last Name _____ First Name _____ M.I. _____

Birth Date _____ Sex: M □ F □

Home Phone _____ Cell _____ Email _____

Mailing Address_____ City _____ Zip _____

Employer _____ Phone _____

Emergency Contact _____ Phone _____

Referred By _____ Family Physician _____

Billing Information: **□ Cash □ Medicare □ Insurance □ Auto Insurance (personal injury)**

*Cash, Check, Credit Card

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ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

By signing below I authorize all insurance payments to be made directly to this Provider, and I also understand that my signature allows the release of my medical record to any "first party" payer as necessary to have the bills paid. Chart copies to a "third party" will only be processed with my valid written authorization and payment of the appropriate fee.

I understand that my "first party" insurance company will be billed directly on my behalf for treatment rendered. I agree to take full responsibility for any remaining balance not paid by my insurance company, including co-pays, deductibles, non-covered services, and services denied by reason of lack of referral, non-participating provider, etc. If treatment is for injuries sustained in an auto accident where payment is pending from a "third party," I understand that my full cooperation will be necessary to secure payment from that party and that, in the event no payment is made, I will be fully responsible for the charges incurred.

I understand that a 24-hour cancellation notice is required to avoid being charged for the missed appointment. I understand my insurance will not cover missed appointments, therefore payment for the missed appointments are my responsibility.

Signature _____ Date _____

Permission to leave a voice/written message on cell phone, landline, on email? □ Yes □ No

Signature: _____ Date: _____

BRADBURY CHIROPRACTIC CLINIC

Confidential Patient Information

NAME: _____

YOUR PRESENT COMPLAINT:_____ Date:_____

BRIEFLY DESCRIBE YOUR SYMPTOMS: _____

WHEN DID THIS FIRST START?: _____

HAVE YOU HAD THIS CONDITION BEFORE? Y □ N□ IF YES, WHEN? _____

LIST OTHER DOCTOR(S) SEEN FOR THIS CONDITION: _____

_____

Is your visit due to an accident? Y □ N□ (If YES, please see receptionist)

Did you sustain an injury at work? **Y □ N□**

Are your injuries accident related? **Y □ N□**

Are you currently employed? **Y □ N□**

Does your employer have a union policy? **Y □ N□**

Is your spouse or family member covered by insurance? **Y □ N□**

Are you covered on their policy? **Y □ N□**

Do you have 2nd insurance? **Y □ N□**

Medical History (if any of the following are relevant to your medical history, please check)

__Muscular Dystrophy	__Rheumatic Fever	__Digestive Disorders	__Cancer	__Polio
__Multiple Sclerosis	__Scarlet Fever	__Sinus Trouble	__Tuberculosis	__Convulsions
__Nervousness	__Backaches	__High Blood Pressure	__Epilepsy	__Asthma
__Numbness	__Heart Trouble	__Concussion	__Dizziness	__Arthritis
__Diabetes	__Hepatitis	__German Measles	__ Venereal Disease	__ Shingles

Describe any operations you've had, and the approx. date: _____

_____

Describe any falls or accidents you had and about when: _____

_____

Have you been treated by a physician for any health condition in the last year? **Y □ N□**

If Yes, Describe Condition: _____

Are you currently taking any medication? **Y □ N□** If Yes, What Kind? _____

_____

Are you allergic to any medication? **Y □ N□** If Yes, What Kind? _____

_____

Are you pregnant? **Y □ N□** Date of last menstrual period: _____

Bradbury Chiropractic and Susan's Acupuncture and Herbal Clinic

FORM: NOTICE OF PRIVACY PRACTICE SUMARY

This summary discloses how health information about you may be used.

Bradbury Chiropractic and Susan's Acupuncture and Herbal Clinic uses health information about you for treatment, to obtain payment for treatment with your authorization as required (check your state laws), for administrative purposes, and to evaluate the quality of care than you receive.

Bradbury Chiropractic and Susan's Acupuncture and Herbal Clinic may use your information to provide information about treatment alternatives or other health-related issues, with your permission.

All new patients that pay 100% out of pocket have the right to restrict patient information to insurance companies.

You may complain to the Privacy Officer, Timothy Bradbury, D.C. and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Bradbury Chiropractic and Susan's Acupuncture and Herbal Clinic must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

If you have any questions or complaints, please contact Timothy Bradbury, D.C. at (360) 715-1185.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices Form.

_____ _____

Signature of patient or authorized representative Date

_____

Printed name if signed on behalf of patient/relationship (parent, legal guardian, personal representative, etc.)

Effective date of this notice is September 1, 2013
This form will be retained in your health record.