

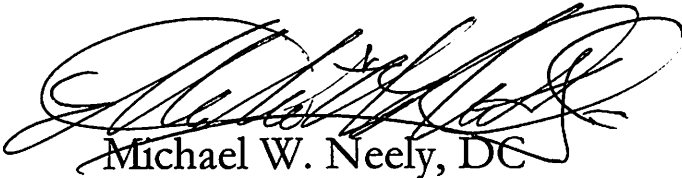


South Sound Pain Relief Clinic - Michael W. Neely, D.C.

3525 Ensign Rd. NE Suite N, Olympia WA 98506
Ph: (360) 943-2940 • Fax: (888) 381-3726

Welcome to SSPRC

Thank you for choosing my office. I will do everything I can to help facilitate healing of the problem or problems that you are experiencing. If I can't help you, I will refer you to most the appropriate healthcare provider who can. Please take a moment to fillout the intake paperwork in its entirety. All the questions are pertinent for the appropriate diagnosis, treatment, and management of your care, so please be as thorough as possible. I look forward to serving your healthcare needs. Thank you again for choosing my clinic.



Michael W. Neely, DC
Chiropractic Physician

CONFIDENTIAL CASE HISTORY FILE

South Sound Pain Relief Clinic
3525 Ensign Rd. NE, Suite N
Olympia, WA 98506
Ph: (360) 943-2940 – Fax: (888) 381-3726

Date: _____
Full Legal Name: _____ Name you prefer: _____
Address: _____ City/State/Zip: _____
Phone (home) () _____ (work) () _____ (cell) () _____ Soc Sec # _____
Birth Date: _____ Age: _____ Sex: _____ Marital Status: S M W D Sep
Spouse's Name: _____ # Children: _____ Years of Education: _____
Emergency Contact: _____ Phone: () _____
Your Employer: _____ Phone: () _____
Employer's Address: _____ City/State/Zip: _____
Job Title: _____ Supervisor Name: _____
Email Address: _____ Referred by: _____

MEDICAL HISTORY (please be complete)

List any surgeries (include dates & reason): _____
List any hospitalizations (include dates & reason): _____
List any auto accident injuries (include dates): _____
List any on the job injuries (include dates): _____
List any current or past major medical conditions you have had (cancer, diabetes, heart disease, arthritis, etc.): _____
List all current over-the-counter and prescription medications used (include reason used): _____

List any health conditions that run in your family (cancer, heart disease, diabetes, arthritis, back problems, etc.): _____

Have you been under a physician's care in the past year? No Yes (reason) _____

When was your last physical examination: _____ Dr: _____

Have you ever been under chiropractic care? No Yes (reason) _____

If female, is there a possibility that you are pregnant? No Yes

Do you smoke/use tobacco? No Yes Exercise habits? Never Occasional Frequent

Check any of the following symptoms you have noticed: (first box = previously, second box = now)

<input type="checkbox"/> <input type="checkbox"/> Headaches	<input type="checkbox"/> <input type="checkbox"/> Leg/foot numbness/tingling	<input type="checkbox"/> <input type="checkbox"/> Memory loss/problems
<input type="checkbox"/> <input type="checkbox"/> Dizziness or light-headed	<input type="checkbox"/> <input type="checkbox"/> Leg/foot fatigue/weakness	<input type="checkbox"/> <input type="checkbox"/> Irritability or depression
<input type="checkbox"/> <input type="checkbox"/> Jaw pain, clicking or locking	<input type="checkbox"/> <input type="checkbox"/> Leg pain with walking	<input type="checkbox"/> <input type="checkbox"/> Fatigue or loss of energy
<input type="checkbox"/> <input type="checkbox"/> Pain or difficulty swallowing	<input type="checkbox"/> <input type="checkbox"/> Abdominal pain	<input type="checkbox"/> <input type="checkbox"/> Fainting or convulsions
<input type="checkbox"/> <input type="checkbox"/> Neck pain or stiffness	<input type="checkbox"/> <input type="checkbox"/> Nausea or vomiting	<input type="checkbox"/> <input type="checkbox"/> Trouble with balance or coordination
<input type="checkbox"/> <input type="checkbox"/> Shoulder pain	<input type="checkbox"/> <input type="checkbox"/> Diarrhea or constipation	<input type="checkbox"/> <input type="checkbox"/> Sleep disturbances/problems
<input type="checkbox"/> <input type="checkbox"/> Mid back pain	<input type="checkbox"/> <input type="checkbox"/> Blood in urine or stool	<input type="checkbox"/> <input type="checkbox"/> Rashes (face, body, limbs)
<input type="checkbox"/> <input type="checkbox"/> Chest pain or cough	<input type="checkbox"/> <input type="checkbox"/> Difficulty or pain w/ urination	<input type="checkbox"/> <input type="checkbox"/> Joint pain or swelling
<input type="checkbox"/> <input type="checkbox"/> Pain/trouble breathing	<input type="checkbox"/> <input type="checkbox"/> Difficulty with sexual function	<input type="checkbox"/> <input type="checkbox"/> Pain with exertion (activity, climbing stairs, etc)
<input type="checkbox"/> <input type="checkbox"/> Arm/hand numbness/tingling	<input type="checkbox"/> <input type="checkbox"/> Abnormal menstrual periods	
<input type="checkbox"/> <input type="checkbox"/> Arm/hand fatigue/weakness	<input type="checkbox"/> <input type="checkbox"/> Sensitive to light or sound	
<input type="checkbox"/> <input type="checkbox"/> Low back pain	<input type="checkbox"/> <input type="checkbox"/> Visual or hearing disturbance	

HAVE YOU HAD ANY OF THE FOLLOWING:

NOW:

Pain worse at night
 Constant pain
 Unexplained weight loss
 Recent bacterial infection (30 days)
 Loss of bowel or bladder control

Urinary discharge
 Recent surgery (30 days)

EVER:

History of cancer
 History of IV drug use
 History of blood transfusion

Information about your current condition/complaints

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What is your **primary** complaint/problem? _____

List other symptoms: _____

When did your symptoms first begin (give date if possible)? _____

How did your symptoms first begin? _____

Pain is: Constant Intermittent

Is your condition getting worse? _____

What activities aggravate your condition? (list) _____

What activities lessen your symptoms? (list) _____

List **all** Doctors/therapists/specialists seen for this problem & treatment given (use back of page if necessary):

1) _____

2) _____

3) _____

Have you had: Xray MRI or CAT scan EMG Bone Scan Blood Work

Who is your family medical doctor? _____

List all home remedies tried for this problem: _____

Is your condition worse at certain times of the day or night? _____

Does your condition interfere with: work: _____ sleep: _____ normal daily routine: _____

Have you had symptoms like this before? No Yes (describe) _____

Regarding your main complaint: 1. RIGHT NOW: 0 _____ 10

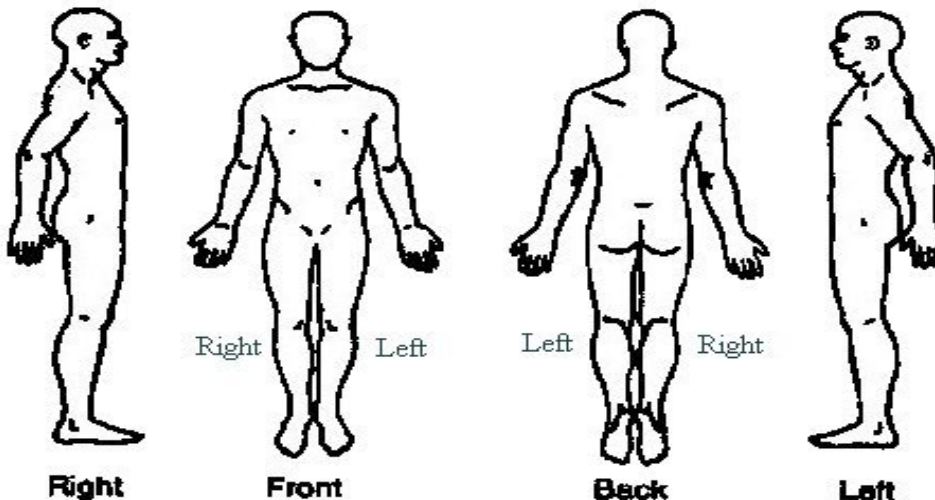
How bad is your pain? 2. AVERAGE: 0 _____ 10

(make a slash on all three scales) 3. WORST: 0 _____ 10

0 = no pain 10 = worst pain imaginable

Draw the area of your symptoms using these symbols: (mark on the figure)

Numbness ----- **Pins & Needles** OOOOO **Burning** AAAAA **Aching** X X X X X **Stabbing** ●●●●●



NOTICE TO NEW PATIENTS: Payment in full for chiropractic services rendered is due in full at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the physician. We value and protect your privacy. I grant permission to the Dr. to use the information in my medical record to assist in the clinical improvement process.

Patient Signature: _____ Date: _____

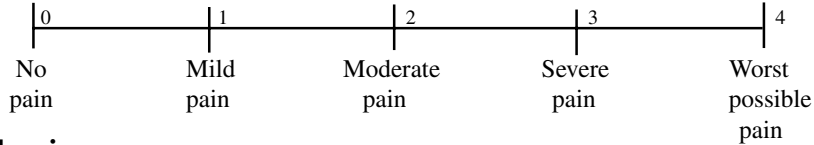
Functional Rating Index

For use with **Neck and/or Back Problems** only.

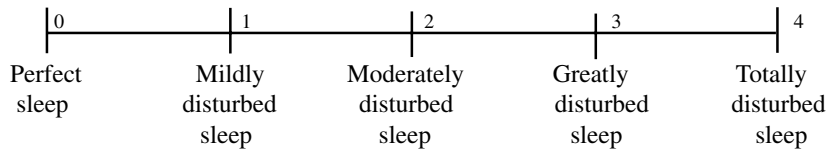
In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.

For each item below, **please circle the number which most closely describes your condition right now.**

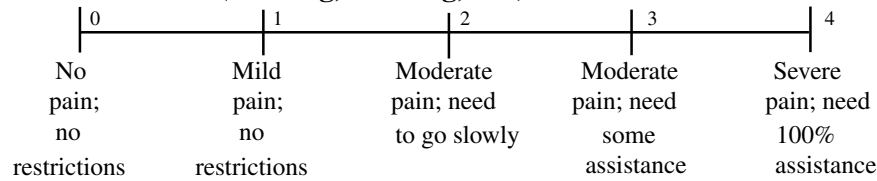
1. Pain Intensity



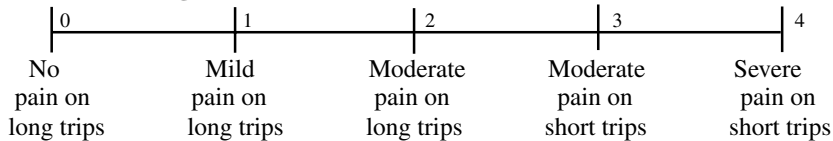
2. Sleeping



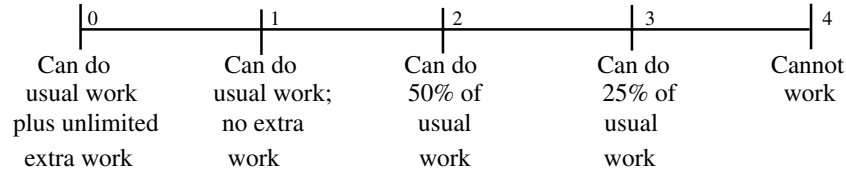
3. Personal Care (washing, dressing, etc.)



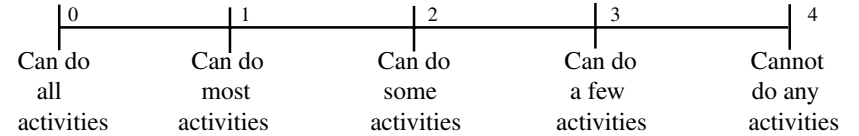
4. Travel (driving, etc.)



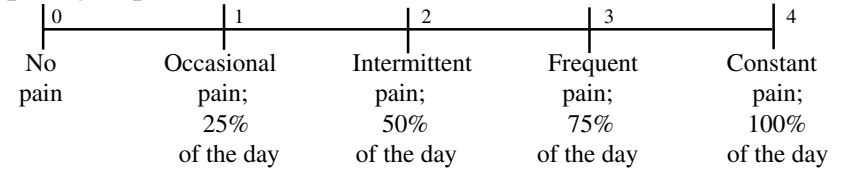
5. Work



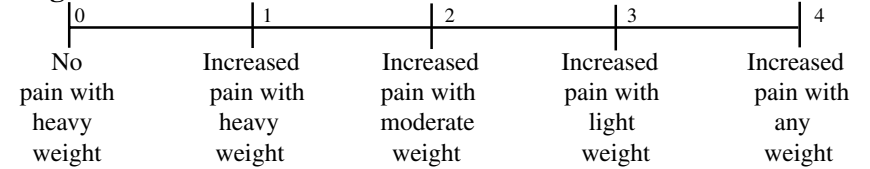
6. Recreation



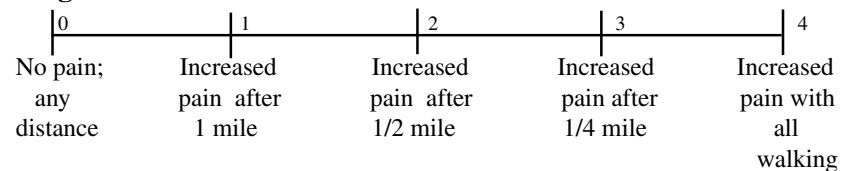
7. Frequency of pain



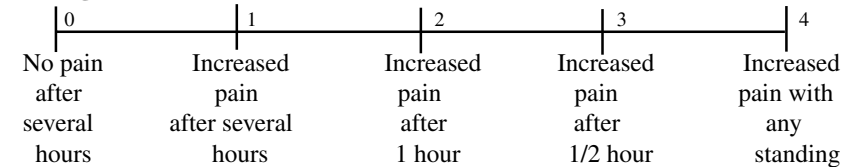
8. Lifting



9. Walking



10. Standing



Name _____

PRINTED

Signature

Total Score _____

Date

Informed Consent

Before beginning treatment it is our office policy to inform you of what to expect, possible complications of chiropractic, as well as complications of other approaches. Remember that all forms of treatment, including non-treatment, have associated risks. **If you have any questions, please be sure to ask the doctor.**

What to expect

The treatment at our office will consist of primarily of manipulation of the joints and soft tissues, using the hands and/or mechanical instruments. You most likely will feel joint movement and hear joint clicks or pops. Soft tissue therapies, therapeutic taping, nutritional consultation, and rehabilitative exercises are adjunct procedures also used to augment chiropractic care.

Chiropractic Risks

Chiropractic is one of the safest methods of conservative care for musculoskeletal injuries. Even so, unexpected complications can occur. Minor, temporary problems, such as soreness and stiffness can occur, especially at the beginning of a treatment plan. Soft tissue therapies can occasionally result in mild bruising, but this is very uncommon. More significant problems, such as fracture of a weakened bone or sprain of a joint, are very rare. One serious and extremely rare complication is stroke following manipulation of the neck. It is estimated that stroke has occurred in less than 1 per 1 million treatments and some studies estimate 1 per 2 million treatments. In the cases where post-treatment stroke has occurred, it is believed that the patients were already predisposed to stroke due to having fragile arteries, where the stroke could have occurred from ordinary activities such as head turning or stargazing.

Other treatment and risks

Medications: Many commonly used medications, such as NSAIDs (Aspirin, Ibuprofen, Aleve) or Tylenol, carry risks of tissue damage, including stomach ulcers or kidney damage. There is a significantly higher risk of developing a serious complication from NSAID use as opposed to chiropractic care. In fact, NSAID abuse is the number one cause of gastrointestinal Other medications can be habit forming and may mask pain, which could allow further tissue damage to occur.

Surgery: While surgery can be necessary as a last resort, it is the treatment of choice in less than 1% of back pain patients. Regardless of your condition, you will be screened for surgical “red flags” and will be referred surgical opinion if it is indicated. Clinical results of surgery for mechanical back pain have been disappointing and expose you to unnecessary hospital and medication risk.

Rest/ Non-treatment: Bedrest has been shown to increase the likelihood of re-occurrence of back episodes and makes chronic pain more likely. Musculoskeletal problems of all types seem to follow this rule. Likewise, non-treatment may lead to a permanent mechanical problems and more severe exacerbations of your problem in the future.

I have read the above and give my consent to begin chiropractic treatment.

Signature _____ Date _____

Printed Name _____



South Sound Pain Relief Clinic - Michael W. Neely, D.C.

2625 B Parkmont Lane SW, Suite A, Olympia, WA 98502

Ph: (360) 943-2940 • Fax: (360) 943-5616

Consent for Treatment of a Minor

I hereby authorize Dr. Michael W. Neely and licensed staff members of South Sound Pain Relief Clinic to administer appropriate therapies (chiropractic care, manual therapies, massage therapy, ice/ heat, etc.) that are within their scope of practice as is deemed necessary to my _____ .

(Indicate relationship to child)

Name of Child: _____

Name of Parent or Guardian: (Print) _____

Signature of Parent or Guardian: _____

Dated at _____ on _____
(City and State) (Date)



Insurance Information

Patient Name: _____ Date: _____

*Referring Physician/ Provider: _____

**All patients billing insurance for massage or being seen under a workers compensation/L&I claim must have a current physician referral at time of service*

Private Insurance Information

Please provide a copy of your current insurance card

Insurance company: _____ Plan/ Program Name _____

Subscriber(ID) # _____ Group # _____

Person who carries insurance: _____

Date of Birth: _____ Social Security #: _____ - _____ - _____

Patient's relationship to the insured:

(circle) Self Spouse/ Partner Child Other _____

Auto Insurance or Workers Compensation/L&I:

Please specify: (circle) Auto Accident(PIP) Workers Compensation/L&I

Claims Adjuster _____ Phone _____

Claim # _____ Date of Injury _____

Employer (if applicable) _____ Employer Phone _____

Patient Signature _____

OFFICE POLICY REGARDING INSURANCE AND FINANCIAL OBLIGATIONS

Payment is expected at the time of service. If you have insurance that covers chiropractic care, we will bill them as a service to you, if you sign an insurance assignment of benefits form. You must supply us with a copy of your insurance card that has your correct ID number, group number and telephone number on it.

If you **do not have** insurance, please be prepared to fully cover the fees for each visit. If you feel you cannot pay for fees at each visit, please discuss potential payment options with Dr. Neely. Payment plans (which must be pre-approved) can be arranged. These accounts are charged monthly interest on the unpaid balance.

- A. **Private or group insurance:** If your insurance covers your chiropractic care, you still may have to pay an annual deductible and/or co-pay at the time of service. As a courtesy to you, we will submit claims to your insurance company, but you must have a signed insurance authorization on file with our office first. It may ultimately be your responsibility to pay for your care regardless of your insurance. Payment for your portion of fees incurred is expected at the time service is rendered.

The provider, *Michael W. Neely, D.C.*, may not waive co-pays or deductible amounts, per regulations as a preferred provider for individual insurance policies. Failure to collect co-pays or deductible amounts could result in the termination of the contract *Dr. Neely* has with your medical insurance. Should there be a financial barrier that will interfere with your treatment, please let us know.

Some insurance companies put marked restrictions on the number of chiropractic visits or the amount paid annual. Your care requirements are based on diagnosis, health status and need for care. Realize that often you will benefit from treatment beyond the limits of your insurance coverage. If your care requirements go beyond a limited coverage benefit, please ask about “cash paying accounts” and “payment plans.”

- B. **Worker’s Compensation:** The Washington Department of Labor and Industries will pay 100% of services and supplies once your claim has been accepted. They will pay only for curative care or a point where you do not seem to make any further progress. *If Labor and Industries denies your claim, you are responsible for payment of services rendered and supplies used at our usual and customary rate.*

Reopening a Closed Claim: Your claim may be reopened, if it can be determined that your present condition is a worsening of your previously accepted condition. *If Labor and Industries denies your reopening application, you are responsible for payment of services rendered and supplies used at our usual and customary rate.*

Please be sure to have all appropriate claim numbers, date of injury, claim managers’ names and billing information if you have seen another doctor or have already opened a claim.

- C. **Accident (Auto, Home, Personal Injury):** If you have PIP (Personal Injury Protection Insurance), your care and treatment will be covered 100% for “medically necessary” care. As a service to you, we will bill your insurance company directly after you sign an insurance authorization and lien form for our office. It is our policy to bill you insurance under PIP, **regardless of who was at fault.** Any services or supplies not covered will become your personal responsibility. You must supply us with correct claim and policy numbers, billing addresses and telephone numbers, claim managers’ names and attorneys’ names, if applicable.

If you do not have PIP or you are waiting for the “at fault” party to reimburse you for your medical expenses, you can pay for your care as follows:

1. Bill your major medical insurance, and pay any co-pays and/or deductibles.
2. Pay at each visit.
3. Establish a monthly payment plan. *In most cases, \$100.00 per month is the minimum required payment.*

Further, if you are waiting to be reimbursed by a third party, you must have a signed lien on file with our office. Your account will be charged interest on the unpaid balance.

D. **Medicare:** this office accepts Medicare assignment. Therefore, you will only be required to pay 20% of the Medicare Maximum Allowable Charge on each visit. Medicare requires spinal x-rays; however, at this time they are not a covered chiropractic service and are not covered with chiropractic referral to a diagnostic x-ray facility. Medicare will not pay for your initial examination, but does pay for up to 24* chiropractic manipulations per year. We request you sign an acknowledgement of non-covered service at each visit.

*Medicare pays for 12 visits and may pay up to 12 more per year when an extension is applied for and accepted.

In order to manage your account correctly with *South Sound Pain Relief Clinic*, it is our policy to verify what your chiropractic insurance benefits are. The verification we receive is not a guarantee of benefits or payment; it is to verify that you do have benefits that can be billed to your insurance. Ultimately it is your responsibility to know the extent of your chiropractic care benefits under your insurance plan.

During your first visit to our office we will inform you as to what type of benefits we were quoted over the phone and tell you what your financial obligation is. It is ultimately your responsibility to know your benefits and what your responsibility is to ensure you get the best benefit from your insurance.

Patient Signature

Date

Form-P-005

Consent for Purposes of Treatment, Payment and Health Care Operations

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

I understand that diagnosis or treatment of me by **Dr. Michael W. Neely** 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. **South Sound Pain Relief Clinic** is not required to agree to the restrictions that I may request. However, if **South Sound Pain Relief Clinic** agrees to a restriction that I request, the restriction is binding on **South Sound Pain Relief Clinic** and **Dr. Michael W. Neely**.

I have the right to revoke this consent, in writing, at any time, except to the extent that **Dr. Michael W. Neely** or **South Sound Pain Relief Clinic** 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 **South Sound Pain Relief Clinic's** Notice of Privacy Practices prior to signing this document.

The **South Sound Pain Relief Clinic's** Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the **South Sound Pain Relief Clinic**.

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

South Sound Pain Relief Clinic 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 accessing the **South Sound Pain Relief Clinic's** web site, 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

Form-P-012 Patient Privacy Summary

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

We are required by law to have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our Notice from time to time. The effective date at the top right hand side of this page indicates the date of the most current Notice in effect.

You have the right to receive a copy of our most current Notice in effect. If you have not yet reserved a copy of our current Notice, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the Notice or your medical information, please contact Dr. Neely or our staff at 360-943-2940.