



**BACK TO BASICS**  
CHIROPRACTIC

**Patient / Insurance Information**

Today's Date: \_\_\_\_\_

How did you hear about our clinic? \_\_\_\_\_

Last Name:		<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	Marital status (circle one)	
First Name:	Middle:	<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	Single / Mar / Div / Sep / Widow	
Email:		Birth date:		Age:	Sex:
Address:		City:		State:	ZIP Code:
Social Security No.:		Home Phone:		Cell Phone:	
Occupation:		Employer:		Employer Phone:	
If Married, Spouse's Name:			If Minor, Parent's Name:		
Emergency Contact Name:		Relationship:		Phone:	

**Primary Insurance**

Insurance Co:	Policy# / ID#:	Group #:	
Subscriber's Name:	Relationship:	Birth date:	SSN:
Subscriber's Employer:	Work Phone:	Home Phone:	

**Do you have Secondary Insurance?**  Yes, Complete Secondary Insurance Section Below  No, Please proceed to Signature Below

**Secondary Insurance**

Insurance Co:	Policy# / ID#:	Group #:	
Subscriber's Name:	Relationship:	Birth date:	SSN:
Subscriber's Employer:	Work Phone:	Home Phone:	

**Were you injured at Work or in an Auto Accident?**  Yes, Complete Following Section  No, Please proceed to Signature Below

**On The Job Injury (Workers Compensation)**

Insurance Co: <input type="checkbox"/> L&I OR <input type="checkbox"/> Self-Insured, Name:	Claim #:	Date of Injury:
Employer Name:	Supervisor:	Phone:
Claim Manager's Name:	Phone:	

**Motor Vehicle Accidents (MVA)**

<b>Patient's Auto Ins Co (Required):</b>	Policy#:	Claim #:
Insurance Adjuster's Name:	Phone:	Accident Date:
Other Vehicles' Drivers' Name:	Phone:	
Other Drivers' Ins Co:	Policy#:	Claim #:
Insurance Adjuster's Name:	Phone:	
Have you Retained an Attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No	Attorney's Name:	Phone:

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



# Medical History Information

Last Name:		<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	Marital status (circle one)	
First Name:	Middle:	<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	Single/Mar/Div/Sep/Widow	
Insurance Co. Name:		Birth date:		Age:	Sex:
<b>Chief Complaint:</b>					
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/> Hip Pain	<input type="checkbox"/> Numbness/Tingling		
<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Shoulder/Arm Pain	<input type="checkbox"/> Leg/Knee Pain	<input type="checkbox"/> Other:		
<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/> Elbow/Hand Pain	<input type="checkbox"/> Headaches			
<b>Current Medications:</b>		Please List:			
<b>Medical Care Information</b>					
Do You Have a Family Doctor?: <input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Doctor:					
Address:		City:	State:	ZIP Code:	
Date of last Visit: / /			Date of last exam: / /		
Have you had surgeries in the last 5 Years: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Last Surgery Date:					
Reason for Surgery:					
<b>Present illness /Conditions:</b>					
<input type="checkbox"/> AIDS	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Spinal Disc Disease	
<input type="checkbox"/> Allergies	<input type="checkbox"/> Cirrhosis/hepatitis	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Thyroid trouble	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/ARC	<input type="checkbox"/> Prostate trouble	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/>
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Dislocated joints	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Ulcer	<input type="checkbox"/>
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Polio	<input type="checkbox"/>
<input type="checkbox"/> Bone fracture	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Mental/ Emotional Difficulty	<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> STD'S	<input type="checkbox"/>
Other:					
<b>Family History of illness:</b>					
<input type="checkbox"/> AIDS	<input type="checkbox"/> Cancer	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Spinal Disc Disease	<input type="checkbox"/> STD'S	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Allergies	<input type="checkbox"/> Bone fracture	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cirrhosis/hepatitis	<input type="checkbox"/> HIV/ARC	<input type="checkbox"/> Mental/Emotional Difficulty	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Polio
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Prostate trouble	<input type="checkbox"/> Thyroid trouble	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Dislocated joints	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/>
Other:					
<b>Type of Cancer:</b> <input type="checkbox"/> Breast <input type="checkbox"/> Lung <input type="checkbox"/> Other:					
<b>Social History:</b>					
Alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes Drinks per week?	Cigarettes? <input type="checkbox"/> No <input type="checkbox"/> Yes Packs per day?	Caffeine? <input type="checkbox"/> No <input type="checkbox"/> Yes Drinks per day?	Exercise? <input type="checkbox"/> No <input type="checkbox"/> Yes Hours per week? (circle one) Light / Moderate / Strenuous		
Misc.:					

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

BACK TO BASICS CHIROPRACTIC

Robert L. Rettig, D.C. / Marshall S. Mathews, D.C. / Bryson J. Bunch, D.C. / Jerad M. Howell, D.C.

8033 W. Grandridge Blvd. Ste. C, Kennewick, WA 99336 / 509-783-BACK (2225) / [www.back2basics.com](http://www.back2basics.com)



## Financial Policy / Terms of Acceptance

### Chiropractic:

Chiropractic is the practice of health care that deals with the diagnosis or analysis and care or treatment of the vertebral subluxation complex and its effects, articular dysfunction, and musculoskeletal disorders, all for the restoration and maintenance of health and recognizing the recuperative powers of the body. (RCW 18.25.005)

### Differential Diagnosis:

Chiropractic differential diagnosis means a diagnosis to determine the existence of a vertebral subluxation complex, articular dysfunction, or musculoskeletal disorder, and the appropriateness of chiropractic care or the need for referral to other health care providers. (RCW 18.25.006)

### Adjustment:

A chiropractic adjustment is a specific directional thrust maneuver or application of forces applied to a subluxated vertebrae that sets the vertebrae in motion with the intent to reduce and/or correct the vertebral misalignment, thus improving the neurological component of the vertebral subluxation complex along with vivification of the affected tissues and body functions. (*Recommended Clinical Protocols and Guidelines for the Practice of Chiropractic*, International Chiropractors Association, 2000)

### Vertebral Subluxation:

A complex of functional and/or structural and/or pathological articular changes that compromise neutral integrity and may influence organ system function and general health. A subluxation is evaluated, diagnosed, and managed through the use of chiropractic procedures based on the best available rational and empirical evidence. (*Recommended Clinical Protocols and Guidelines for the Practice of Chiropractic*, International Chiropractors Association, 2000)

### Massage Therapy:

Due to the limited availability of our massage therapists, it is important that appointments are kept. As a courtesy, we do reminder calls when possible, but it's your responsibility to remember your appointment. **24 hours** cancellation notice is required for massage appointments. If 24 hrs notice is not given, a fee of **\$75.00** will be assessed. This charge is not covered by insurance. You will be required to pay this fee before future appointments can be scheduled.

### Services Rendered:

I agree to pay for services rendered as the patient as the charge is incurred. **I understand that it is my responsibility to know my health plan coverage and co-pay/co-insurance. I understand payment is expected at the time of service.** I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself and that I am personally responsible for payment of any and all provided services covered or non-covered. I also understand that if I terminate care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered. I hereby release them of any consequences thereof. I agree that a photocopy of this agreement shall serve as the original.

I hereby authorize any direct payment of any chiropractic/massage/medical expense benefits allowable to the doctor as payment toward the total charges for professional services. This payment will not exceed my indebtedness to the assignee. I agree that a photocopy of this agreement shall serve as the original.

### Minors:

Who ever brings the child in is responsible for making any applicable payments. In case of divorce or separation, the responsibility for minors rests with the accompanying parent. Divorce decree is between the mother and father. Your doctor is **NOT** a part to your divorce decree. If the decree requires the other parent to pay all or part of the cost, parents are responsible for working the financials out between themselves.

### Outstanding Balances:

After your insurance company has paid their portion; balances are due in full upon receipt of your first statement. **I understand that there will be a finance charge of 12% annually for the patient responsibility unpaid balance.** When account balance becomes 90 days past due, we have the right to take necessary steps to collect this debt. Collection balances need to be paid in full before future appointments will be scheduled.

**Insurance and Disability Forms:** Prepayment is required for completion of Disability, Family & Medical Leave Act (FMLA) forms and any other forms requested by the patient. Please allow 5-7 working days for forms to be prepared.

**Motor Vehicle Accidents (MVA):** If there is no Personal Injury Protection (PIP) coverage on your auto insurance policy, or if the PIP fund has been exhausted, we will arrange a financial agreement on a case by case basis where monthly payments will be made until settlement is reached. Services will be billed to the responsible party according to the current fee schedule.

***We have the right to ask for your Social Security Number (SSN) and/or your Driver's License Number because we accept personal checks and extending unsecured credit. In order for us to bill any remaining balance after your insurance has paid, we need your SSN as a condition of extending credit.***

I have read and understand the above statements. All questions regarding my doctor's objectives pertaining to my care in the office have been answered to my complete satisfaction. I therefore accept chiropractic/massage care on this basis.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Legal Guardian

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## Notice of Privacy Practices

**This notice describes how medical information about you may be used and disclosed, and how you can get access to this information.** The Doctors and the staff respect your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so. The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnosis, treatment, health information from other providers, and billing and payment information relating to services. Federal and state laws allow us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

### **Examples of Use and Disclosures of Protected Health Information for Treatment, Payment and Health Operations.**

#### **For Treatment**

Information obtained by a nurse, physician or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you. We may also provide information to others providing you health care. This will help them stay informed about your care.

#### **For Payment**

We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnosis, procedures performed, or recommended care. Once the appropriate insurance has fulfilled their obligation on your behalf, the unpaid balance becomes the responsibility of the patient. If at any time Back to Basics needs to hire a third party agency or agent in order to collect this expense will be passed on to you the patient.

#### **For Health Care Operations**

We use your medical records to assess quality and improve services. We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff. We may use and disclose your information to conduct or arrange for services including: medical quality review by your health insurance services; accounting, legal, risk management, and insurance services; audit functions, including fraud and abuse detection, and compliance programs. We may contact you to remind you about appointments.

#### **Opting-Out of Communication**

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us in writing (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

#### **Your Health Information Rights**

The health and billing records we create and store are the property of the practice/health care facility. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice:
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant this request. But we will comply with any request granted.
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information.
- Request that you be allowed to see and get a copy of your protected health information. (You may make this request in writing. We have a form available for this type of request).
- Have us review a denial of access to your health information – except in certain circumstances.
- Ask us to change your health information. You may give us this request in writing. We have a form available for this type of request. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of records.
- When you request, we will give you a list of disclosures of your health information. The list will not include disclosures to third party payers. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

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### **Our Responsibilities**

We are required to: Keep your protected health information private; Give you this Notice; Follow the terms of this Notice.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our office to pick one up.

### **To Ask For Help or Complain**

If you have questions, want more information, or want to report a problem and the handling of your protected health information, you may contact:

*HIPAA Privacy Officer*  
8033 W. Grandridge Blvd., Suite C  
Kennewick, WA 99336  
(509) 783-2225

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may deliver a written complaint to any person at our practice/health care facility. You may also file a complaint with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

### **Other Disclosures and Uses of Protected Health Information Notification of Family and Others**

Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family and friends your condition and that you are in the hospital. In addition, we may disclose health information about you to assist in disaster relief efforts.

### **Object to Disclosure**

You have the right to object to this use or disclosure of your information. If you object, we will not use or disclose it.

### **Other Disclosures Not Named In This Notice**

Uses and disclosures not in this notice will be made only as allowed or required by law or with your written authorization.

### **We May Use and Disclose Your Protected Health Information Without Your Authorization As Follows:**

- Medical Researchers – if the research has been approved and has policies to protect the privacy of your health information. We may also share your information with medical researchers preparing to conduct a research project.
- To Funeral Directors and Coroners consistent with applicable law to allow them to carry out their duties.
- To Organ Procurement Organizations (tissue donation and transplant) or persons who obtain, store, or transplant organs.
- To the Food and Drug Administration (FDA) relating to problems with food, supplements, and products.
- To comply with Worker's Compensation Laws if you make a worker's compensation claim.
- For Public Health and Safety purposes as allowed or required by law: a) to prevent or reduce a serious, immediate threat to the health or safety of a person or the public. b) to public health or legal authorities.
- To protect public health and safety.
- To prevent or control disease, injury or disability.
- To report vital statistics such as births and deaths.
- To report suspected abuse or neglect to public authorities.
- To correctional institutions if you are in jail or prison, as necessary for your health and the health and safety of others.
- For law enforcement purposes such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.
- For health and safety oversight activities. For example, we may share health information with the Department of Health.
- For disaster relief purposes. For example, we may share health information with disaster relief agencies to assist in the notification of your condition to family or others.
- For work related conditions that could affect employee health. For example, an employer may ask us to assess health risks on a job site.
- To the military authorities of U.S. and foreign military personnel. For example, the law may require us to provide information necessary to a mission.
- In the course of judicial and/or administrative proceedings at your request or as directed by a subpoena or court order.
- For specialized government functions. For example, we may share information for national security purposes.

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**NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT and  
PATIENT CONSENT FOR USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION**

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting:

*Back to Basics Compliance/Privacy Officer  
8033 W. Grandridge Blvd., Suite C  
Kennewick, WA 99336  
(509) 783-2225*

With my consent, Back to Basics Chiropractic may use and disclose protected health information about me to carry out treatment, payment, and healthcare operations. Please refer to Back to Basics Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Back to Basics Chiropractic reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the above address.

With my consent, Back to Basics Chiropractic may contact me at my home or other designated location, in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations (for example, appointment reminders, insurance items, and/or any call pertaining to clinical care).

With my consent, Back to Basics Chiropractic may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment, and healthcare operations (for example, appointment cards, special occasion cards, and/or statements).

With my consent, Back to Basics Chiropractic may e-mail to my home or other designated location any items that assist the practice in carrying out treatment, payment, and healthcare operations (such as appointment reminder cards and patient statements). I have the right to request that Back to Basics Chiropractic restrict how it uses or discloses my protected health information to carry out treatment, payment, and healthcare operations. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

By signing this form, I am giving my consent to Back to Basics Chiropractic's use and disclosure of my protected health information to carry out treatment, payment, and healthcare operations. By signing this form, I also acknowledge receipt of the **Notice of Privacy Practices**.

I may revoke my consent in writing except to the extent that Back to Basics Chiropractic has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Back to Basics Chiropractic may decline to provide treatment to me.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Legal Guardian