

822 Sleater Kinney Rd Ne STE B Olympia Wa 98506 (360) 556-5707

[Holmesfamilychiropractic@gmail.com](mailto:Holmesfamilychiropractic@gmail.com)

**Patient Information**

|  |  |
| --- | --- |
| First name Mid Initial \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Home Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| City, State, Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | State, Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Home Phone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Marital Status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Cell Phone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Nearest relative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Work Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | City, State, Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Phone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| What is your Occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

**CHECK SYPMTOMS YOU ARE SUFFERING WITH:**

|  |  |  |  |
| --- | --- | --- | --- |
| * Stiff Neck | * Fatigue | * Pins and Needles in Arms | * Irritability |
| * Neck Pain | * Depression | * Pins and Needles in Legs | * Loss of Smell |
| * Mid Back Pain | * Shortness of Breath | * Numbness in fingers | * Nervousness |
| * Low back Pain | * Lights bother Eyes | * Numbness in toes | * Hand Cold |
| * Hip Pain | * Loss of memory | * Headache | * Feet Cold |
| * Pain Down Legs | * Loss of Sleep | * Dizziness | * Tension |
| * Tight muscles | * Loss of Balance | * Ringing Ears | * Shoulder Pain |
| * Chest Pain | * Head seems too Heavy | * Fainting | * Knee Pain |

Purpose of Visit (Major Complaint) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did it start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Doctors Seen for this condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had any spinal operations? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What medications are you taking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If female, are you pregnant? \_\_\_\_ Yes \_\_\_\_\_ No

What kind of care do you desire? \_\_\_ Long Lasting Correction \_\_\_\_ Temporary Relief

**Payment is Expected at Time of Visit**

Name of person responsible for payment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you insured? \_\_\_\_ No \_\_\_\_Yes, Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been to a Chiropractor before? \_\_\_ No \_\_\_\_ Yes, Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our practice? \_\_\_ Friend \_\_\_ Sign \_\_\_\_ Referred by Dr. \_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patients Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



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OUR OBJECTIVE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential that we are working together towards the same objective.

It is important that each patient understand both the objective and the method that will be used to accomplish the objective. This will prevent any confusion or disappointment.

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 in the spinal column which causes alteration o0f 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.

ADJUSTMENT: An adjustment is the specific application of force to facilitate the body’s correction of a vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

We do not offer to diagnose or treat any disease or condition other, that the vertebral subluxation. However, if during the course of chiropractic spinal examination, we encounter non chiropractic or unusual findings, we will advise you. In those rare circumstances, regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding the treatment prescribed by others. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have read and understand the above statement.

(Print Name)

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

Patient Name

**Holmes Family Chiropractic INFORMED CONSENT**

**To the patient:** Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

# The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible “pop” or “click,” much as you have experienced when you “crack” your knuckles. You may feel a sense of movement.

# Analysis/Examination/Treatment

As a part of the analysis, examination and treatment, you are consenting to the following procedures:

|  |  |
| --- | --- |
| Spinal manipulative therapy | Postural analysis |
| Range of motion testing | Hot/cold therapy |
| Muscle strength testing | Vital signs |
| Radiographic studies | Palpation |
| Basic neurological testing | Myofascial Release Therapy |
| Orthopedic testing | Mechanical Traction |

**The material risks inherent in chiropractic adjustment** As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care;

however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

# The probability of those risks occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

**The availability and nature of other treatment options.** Other treatment options for your condition may include:

* Self-administered, over-the-counter analgesics and rest
* Medical care and prescription drugs such as anti-inflammato-ries, muscle relaxants and pain-killers
* Hospitalization
* Surgery

If you choose to use one of the above noted “other treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

# The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this growth may complicate treatment making it more difficult and less effective the longer it is postponed.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BOX AND SIGN BELOW.**

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Date Date

Patient’s Name (Printed) Doctor’s Name (Printed)

Patient’s Signature Doctor’s Signature

Signature of Parent or Guardian (if a minor)

**Holmes Family Chiropractic Financial Policy**

The following is an explanation of our clinic policy. We believe that a clear definition of our policy will allow us both to concentrate on the big issue–re-establishing, retaining and maintaining your health. We will be happy to answer any questions you have regarding our policy, your account and your insurance coverage.

**Payments**

At Holmes Family Chiropractic your health care needs are our primary concern. We do not want finances to get in the way of you getting the health care that you need. Policies are in place in an attempt to assist you in meeting your financial obligations without increasing stress in your life.

* **If you do not have insurance ALL payments are expected at the time of service. Prepayments are also allowed.**
* **If you have insurance ALL COPAYS & CO-INSURANCE are due at time of service.**

**By taking care of this while you are in the office the need for an invoice is minimized.**

* **There will be a 1% finance charge added to all balances after 60 days. Maximum charge is 12% per year.**
* **There will be a $25.00 charge on all returned checks.**
* If you need any additional documentation other than a receipt please feel free to ask the front desk as we are able to provide that to you at no additional charge.

**Insurance Coverage**

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment. If claims denial is received after the insurance has processed, the balance will be Patient Responsibility.

**X-rays**

We will release your X-rays to another doctor only after you sign a release/transfer form and your account has been paid in full, unless you have been referred for a consultation. We need 48 hour notice to enable us to mail X-rays in time for your appointment.

**Appointment/Treatment**

Holmes Family Chiropractic is a very busy clinic and when an appointment is scheduled for you, we reserve that time for you only. There will not be a fee for rescheduling or canceling an Adjustment. ***However, for Massage Therapy, there is a $75 fee if an appointment is not cancelled more than 24 hours in advance. A credit card must be on file for ALL MASSAGE PATIENTS, no exceptions. The credit card will be on file and charged automatically if there is a no-show or cancellation less than 24 hours in advance.***

**Release and Wellness**

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

*I have read and understand Holmes Family Chiropractic’s office policies and I will honor them.*

Patient’s Printed Name:

Signature: Date:

|  |  |
| --- | --- |
| Witness: | Date: |
| **Credit card on file with us:**  Card# | Exp Date: |
| Name as it Appears on Card: |  |

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