MONTALAND & MCGRATH CHIROPRACTIC CENTER

Confidential Patient Information

Name:_____ Date:_____

Is your visit due to an accident or work injury? ❑Yes ❑No If yes, please see receptionist for an accident report form.

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Sex:_____ Date of Birth:_____ Email:_____

Occupation:_____ Company:_____ Location:_____

Emergency Contact (not your spouse):_____ Phone:_____

If this is for a child under 18 please fill out the following.

Guardian's full name:_____ Date of Birth:_____ Social Security #:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Who referred you to the office?_____ To a certain provider?_____

YOUR PRESENT COMPLAINT (BRIEFLY DESCRIBE YOUR SYMPTOMS):_____

_____

When did you first notice these symptoms?_____

List other doctor(s) you've seen for this condition:_____

Personal Medical History: If any of the following are relevant to your medical history, please check the box.

❑ Cancer	❑ Muscular Dystrophy	❑ Rheumatic Fever	❑ Digestive Disorders	❑ Sciatica
❑ Polio	❑ Multiple Sclerosis	❑ Scarlet Fever	❑ Sinus Trouble	❑ Headache
❑ Tuberculosis	❑ Convulsions	❑ Nervousness	❑ Backaches	❑ Migraine
❑ High Blood Pressure	❑ Epilepsy	❑ Asthma	❑ Numbness	❑ Shoulders
❑ Heart Trouble	❑ Concussion	❑ Dizziness	❑ Arthritis	❑ Knees
❑ Diabetes	❑ Hepatitis	❑ German Measles	❑ Venereal Disease	❑ Hips

Describe any operations you've had and the dates:_____

Have you been treated by a physician for any health condition in the last year? _____

Describe Condition:_____ Date of Last Physical Exam:_____

Primary Doctor:_____ Phone:_____

Are you taking any medication? ❑Yes ❑No What Kind?_____

Are you allergic to any medication? ❑Yes ❑No What Kind?_____

Are you pregnant? ❑Yes ❑No Estimated due date:_____ Date of last menstrual period:_____

Do you have insurance? ❑Yes ❑No Insurance Company:_____

Member ID #:_____ Group #:_____ Primary Card Holder Name:_____

I understand and agree that health and accident insurance policies are an arrangement between myself and the insurance carrier. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the convenience of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if Montaland McGrath Chiropractic Center extends credit to me and I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made. I hereby authorize the doctors at Montaland McGrath Chiropractic Center and whomever they may designate as their assistants to administer treatment as they so deem necessary and I also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above information is true and correct.

Patient's (Parent or Guardian's) Signature:_____

MONTALAND & MCGRATH CHIROPRACTIC CENTER

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I, _____, hereby state that by signing this consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for the treatment and to carry out its health care operations. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a.) a postcard mailed to me at the address provided by me; and b.) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, including filing medical liens which would involve limited disclosure of patient identification and diagnosis, and as necessary for the Practice to conduct its specific health care operations.

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____

Name of individual (Printed) Signature of Individual

_____ _____

Signature of Legal Representative (e.g., Attorney-In-Fact, Guardian, Parent if a minor) Relationship

Date Signed_____ Witness:_____

Montaland McGrath Chiropractic Center

MASSAGE APPOINTMENT CANCELLATION POLICY

Please arrive at least ten minutes before your scheduled appointment time in order to ensure a full massage session. You may cancel your appointment without charge up to 24 hours preceding your appointment. Less than 24 hours cancellations will be charged $40. Montaland McGrath Chiropractic Center, Ps, Inc will not bill your health insurance company under any circumstances for the cancellation fee, or the session missed. If you do not call to cancel your appointment or do not show up for your scheduled appointment, you will be charged full price for the scheduled service.

_____ _____

Name of individual (Printed) Date

_____

Signature of individual

MONTALAND MCGRATH CHIROPRACTIC

Pain Diagram

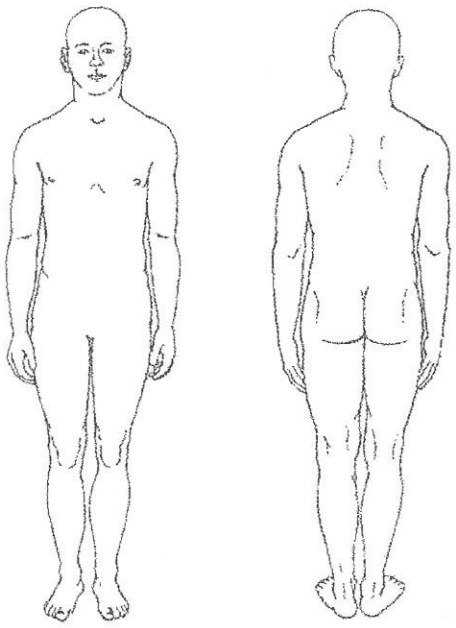
Patient Name:_____

SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

Mark areas on the body where you feel the described sensations
Use the appropriate symbols
Mark areas of radiation
Include all affected areas

Numbness	Pins & Needles	Burning	Aching	Stabbing
.....	ooooo	xxxxx	*****	/////
.....	ooooo	xxxxx	*****	/////
.....	ooooo	xxxxx	*****	/////
.....	ooooo	xxxxx	*****	/////

Please mark on the pain scale from 0 to 10 the pain you feel with this condition.
10 being the worst pain you have felt with this condition.



Neck-Shoulder-Arm-Pain

On a scale of zero to ten, I rate my Discomfort as follows:

(_____)
0 10

Mid Back Pain

On a scale of zero to ten, I rate my Discomfort as follows:

(_____)
0 10

Low Back and Leg Pain

On a scale of zero to ten, I rate my Discomfort as follows:

(_____)
0 10

_____ _____

Date Signature

MONTALAND & MCGRATH CHIROPRACTIC CENTER

REQUEST OF RECORDS

Date:_____

Patient:_____ DOB:_____

To (Doctor, Clinic or Hospital): _____

Address: _____

City: _____State: _____ Zip: _____

Phone:_____ Fax:_____

I hereby authorize the release of my

_____

_____

or copies of such and request that they be transferred to:

Montaland & McGrath Chiropractic Center
Dr. Alexie Montaland, D.C.
or
Dr. Thomas Gentry McGrath, D.C.

14405 NE 20th Street
Bellevue, WA 98007
Fax: 425-641-5337 Phone: 425-641-2527

Print Name of Patient_____

Patient's Signature_____