VALENTE
CHIROPRACTIC

Patient Registration

Name: _____ **Date:** _____
Last First Middle

Nickname or Preferred Name: _____

Sex: ☐ Male ☐ Female **Date of Birth:** ___/___/___ **Age:** _____

Address: _____

City _____ **State** _____ **Zip** _____

Social Security # ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Driver's License # _____

I would like to be notified of my upcoming appointments by:
☐ Text Message
☐ E-mail Message
☐ No Notification Please

Contact:
Home Phone (_____) _____
Work Phone (_____) _____ EXT
Cell Phone (_____) _____ Carrier: _____
E-mail Address: _____

Whom may we thank for referring you? _____

Marital Status:
☐ Single
☐ Married
☐ Separated
☐ Divorced
☐ Widowed
☐ Partnered for ____ years
Spouse's name:
_____

Race:
☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian
☐ Other Pacific Islander
☐ White

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Preferred Language:
_____

Employment:
☐ Employed (FT)
☐ Employed (PT)
☐ Self-Employed
☐ Unemployed
☐ Homemaker
☐ Active Military
☐ Retired
☐ Disabled
☐ N/A
☐ Full-time Student
☐ Part-time Student
☐ Not a Student

Employer: _____
Occupation: _____
School: _____

IN CASE OF EMERGENCY, CONTACT:
Name _____ Relationship _____
Home # (____) _____ Cell # (____) _____ Work # (____) _____

Accident/Injury Information

Is your condition due to an Auto Accident? ☐ No ☐ Yes Date: _____
Is your condition due to an injury sustained at Work? ☐ No ☐ Yes Date: _____
Is your condition due to another form of accident? ☐ No ☐ Yes Date: _____

If YES please explain: _____

To whom have you made a report of your accident?
☐ L&I ☐ Worker Comp ☐ Employer
☐ Auto Insurance ☐ Other

Attorney Name (if applicable):
_____

VALENTE
CHIROPRACTIC

Patient Current Condition and Pain Form

Name _____ **Date** _____

Complaint/Pain Location(s) (example: neck, upper back, mid-back, low-back, hips, extremities):

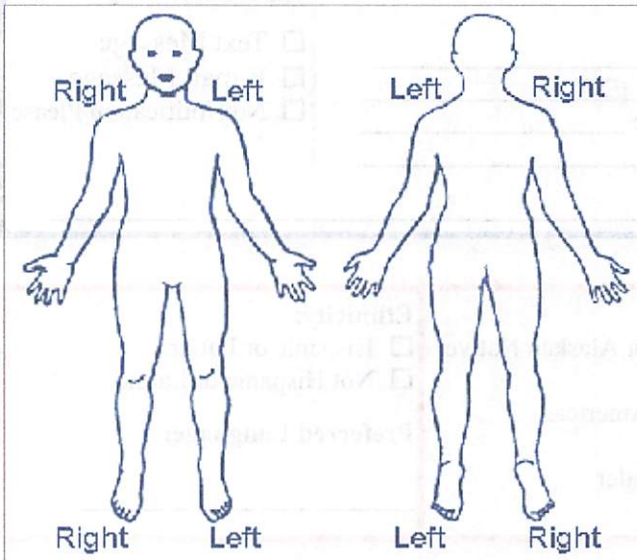
_____

Usual Pain Intensity

No pain 0 1 2 3 4 5 6 7 8 9 10 Severe pain

Today's Pain Intensity

No pain 0 1 2 3 4 5 6 7 8 9 10 Severe pain



Front Back

On the image please indicate where you are experiencing your symptoms.

How would you describe the character of your condition/pain? (please check all that apply)

☐Sharp ☐Dull ☐Tingling ☐Numb
☐Aching ☐Shooting ☐Radiating ☐Burning
☐Throbbing ☐Cramping ☐Stiffness ☐Swelling
☐Other _____

How often do you experience your symptoms?

☐ Constantly (76%-100% of the time)
☐ Frequently (51%-75% of the time)
☐ Occasionally (26%-50% of the time)
☐ Intermittently (0%-25% of the time)

When do you experience your symptoms?

Ex: every day, most days, some days, a few times a year

_____

Does your condition interfere with your.... (please check any that apply)

☐ Sleep ☐ Work ☐ Daily routine ☐ Recreational activities

	Comfortable	Uncomfortable	Painful
Lying down	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Stretching	☐	☐	☐
Walking	☐	☐	☐
Running	☐	☐	☐
Bending	☐	☐	☐
Lifting	☐	☐	☐
Kneeling	☐	☐	☐
Pulling	☐	☐	☐
Reaching	☐	☐	☐
Other _____	☐	☐	☐

Additional information / Any recent falls and/or injuries / Prior condition related medical history

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

VALENTE
CHIROPRACTIC

Health History:

It will be assumed that any space left blank indicates that you have NOT had that test, exam, illness, disease, surgery, ect.

A. Date of last:

Physical Exam:	**Medical Doctor:**	**Bone Scan:**	**CT-Scan:**
Chiropractic:	**Chiropractor:**	**Spinal X-Ray:**	**MRI:**
Physical Therapy:	**Physical Therapist:**	**Chest X-Ray:**	**Blood Test:**
Massage Therapy:	**Massage Therapist:**	**Dental X-Ray:**	**Other:**

B. Injuries, traumas, allergies, and illnesses:

Broken Bones/Fractures: _____ Head Injuries: _____

Dislocations: _____ Falls: _____

Please check the box to indicate if you have or have had any of the following:

☐ AID/HIV	☐ Breast Lump	☐ Epilepsy	☐ Herpes	☐ Mumps	☐ Psychiatric Care	☐ Tuberculosis
☐ Alcoholism	☐ Bronchitis	☐ Glaucoma	☐ High Blood Pressure	☐ Osteoporosis	☐ Rheumatoid Arthritis	☐ Tumors, Growths
☐ Allergy shots	☐ Bulimia	☐ Goiter	☐ High Cholesterol	☐ Pacemaker	☐ Rheumatic Fever	☐ Typhoid Fever
☐ Anemia	☐ Cancer	☐ Gonorrhea	☐ Kidney Disease	☐ Parkinson's Disease	☐ Scarlet Fever	☐ Ulcers
☐ Anorexia	☐ Cataracts	☐ Gout	☐ Liver Disease	☐ Pinched Nerve	☐ STD(s)	☐ Vaginal Infections
☐ Appendicitis	☐ Chemical Dependency	☐ Heart Disease	☐ Measles	☐ Pneumonia	☐ Stroke	☐ Whooping Cough
☐ Arthritis	☐ Chicken Pox	☐ Hepatitis	☐ Migraine Headaches	☐ Polio	☐ Suicide Attempt	☐
☐ Asthma	☐ Diabetes	☐ Hernia	☐ Mononucleosis	☐ Prostate Problem	☐ Thyroid Problems	☐
☐ Bleeding Disorders	☐ Emphysema	☐ Herniated Disk	☐ Multiple Sclerosis	☐ Prosthesis	☐ Tonsillitis	☐

Other illness or injury: _____

Allergies (ex: seasonal, peanuts) &/or Medication Allergies (ex: Penicillin, NSAID):

_____ ☐ **NO Known Allergies**

_____

C. Surgeries:

Type of Surgery	Date	Surgeon/Hospital

D. Current Medications: (if certain attributes of your medication(s) are unknown, please write unknown)

Medications or Vitamins/Herbs/Minerals	Dosage (mg)	Frequency	Prescribing Doctor
☐ **NO Current Medications**			

E. Females- Pregnancies and outcomes:

Are you currently pregnant? ☐ No ☐ Yes **Due Date :** _____

Prior pregnancies, dates of delivery, and outcomes: _____

VALENTE
CHIROPRACTIC

2. What previous care/treatment have you received for your condition?

☐ Physical therapy ☐ Chiropractic care ☐ Medication ☐ Surgery ☐ None ☐ Other: _____
Have you ever received Chiropractic Care? ☐ Yes ☐ No If yes, when? _____

3. Family Health History:

Associated health problems of relatives _____

_____

_____

4. Social and Occupational History:

A. Level of Education:

☐ High school ☐ Some college ☐ College graduate ☐ Post graduate studies
☐ Currently attending _____

B. Job description, work schedule, and work activity (eg: sitting, standing, light/heavy labor)**:**

_____

_____

C. Habits:

Do you smoke or use tobacco products?
☐ Current Every Day Smoker ☐ Current Some Day Smoker ☐ Former Smoker ☐ Never Smoker
☐ Other: _____

Do you consume alcohol? ☐ Yes ☐ No
Amount:_____

Do you consume coffee or other caffeinated drinks? ☐ Yes ☐ No
Amount:_____

Are you under a lot of stress? ☐ Yes ☐ No
Reason:_____

D. Recreational activities:

_____

_____

F. Exercise:

Type(s):_____
(e.g: walking, running, aerobic activities, yoga, rock climbing, pool activities, softball, core training, weight lifting)

Frequency:_____
(e.g: 3 times a week, daily, twice daily, rarely, never)

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize Dr. Valente/Valente Chiropractic to provide me with chiropractic care, in accordance with Washington state's statutes.

Signature _____ Date _____

Printed Name: _____

Doctor's Signature _____ Date _____

HIPAA NOTICE OF PRIVACY PRACTICES
SUMMARY AND DISCLOSURE

Valente Chiropractic
Effective Date: February 9, 2012

Our HIPAA Notice of Privacy Practices describes the privacy practices of Valente Chiropractic. We respect our legal obligation to keep health information that identifies you private, and by law, we are obligated to provide you a notice of our privacy practices.

We are required by law to maintain the privacy of your health information, to follow the terms of our Notice that are currently in effect, and if you request, to provide you a copy of our Notice regarding our privacy practices and legal duties in respect of you and the information we collect and maintain regarding your health information. Our Notice also describes your rights regarding your health information and certain obligations that mandate how we use and disclose your health information.

Your Rights You may...
-Request to inspect any copy of your records.
-Request to amend incomplete or inaccurate information in your records.
-Receive an accounting of certain disclosures of your health information.
-Ask for additional privacy protections (although your request may be declined).
-Ask for confidential communications in a particular manner.
-Receive a paper copy of this Notice.
-File a complaint without penalty.

Use and Disclosures. We will not use or disclose your information unless you tell us to do so or unless the law allows or requires us to do so. We use and disclose your information:
-For treatment, payment, and health care operations.
-Through patient scheduling; to notify family or a close friend you have entrusted with your care; or for notification after benefits and services.
-As permitted or required by the law.
-For certain activities when the law requires it, such as: public health, reporting of abuse, neglect, or domestic violence; health oversight; lawsuits and disputes; law enforcement activities; coroner; medical examiner, or funeral director purposes; organ donation; avoidance of a serious threat to health or safety; workers' compensation; and national security.
-With your authorization.

Changes to this Notice We reserve the right to change this Notice at any time as allowed by law. Updated Notices will be in our office and paper copies will be available upon request.

Complaints If you believe that we have not properly respected the privacy of your health information, you may file a complaint with our clinic by contacting an Office Manager by calling (509) 467-7991 or (509) 467-0057, sending a letter to our office address, or by e-mailing admin@valentechiropractic.com.

Please indicate below if we may discuss your health information, appointment scheduling and/or billing with someone you trust:

☐ **Spouse:** _____ ☐ Yes, Health Info ☐Yes, Billing Info ☐Yes, Scheduling

☐ **Parent/s or Guardian/s:** _____
☐ Yes, Health Info ☐Yes, Billing Info ☐Yes, Scheduling

☐ **Relative/Friend/Other:** _____ **Indicate Relationship:** _____
☐ Yes, Health Information ☐Yes, Billing Information ☐Yes, Appointment Scheduling

Acknowledgment of Receipt of this Notice As a patient of Valente Chiropractic, I acknowledge that I have received and seen this notice and understand that I may request a copy of the full HIPAA Notice Privacy Practices for additional information. I understand that Valente Chiropractic respects their legal obligation to keep health information private unless required by law. My signature below indicates that I agree to these conditions.

Printed Patient Name: _____

Signature of Patient _____ Date _____
(Parent or Guardian Signature if Patient is a Minor)

VALENTE
CHIROPRACTIC

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with care, alternatives, and potential effects on your health if you choose not to receive care.

We may conduct some diagnostic or examination procedures, if indicated. Any examinations or tests conducted will be carefully performed, but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or instruments to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all health care interventions, there are some risks to care including, but not limited to: muscle spasms, aggravation and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from hot or cold therapies such as heat and ice packs, fractures, disc injuries, strokes, sprains, strains, and dislocations. With respect to strokes, there is a rare but serious condition known as arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with potential to lead to a stroke. This occurs in 3-4 of every 100,000 people, whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic treatment can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care, massage therapy, and manual therapy as it is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers at Valente Chiropractic PLLC for my present condition and for any future condition(s) for which I seek chiropractic care, massage therapy, or manual care.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Valente Chiropractic Financial Policy

If you have insurance that we are in network with, we will make a copy of your card and collect any copay or coinsurance that is due. Once we receive an EOB (Explanation of Benefits) from your insurance company, we will send you a statement if there is a balance remaining for us to collect.

If you have insurance that we are *not* in network with, you may contact your insurance company to see if they will reimburse you for visiting an out of network provider. You will be responsible for providing payment at the time of service. We will assist you by providing receipt of your treatment in our office, or that you may seek reimbursement form your insurance company.

Please be aware that some insurance companies require pre-certification for chiropractic care. Some insurance companies may also require a referral from your primary care physician. Care will commence once any necessary approval or referrals have been obtained.

Common insurance terms:

Allowed Amount: For the insurance companies that we are in-network with, there is an amount that we have agreed to receive as payment for our services. This contracted amount is sometimes less than our standard fee schedule. This "allowed amount" will be made by a combination of the patient and the insurance company, sometimes wholly by one party or the other. How much of this amount the insurance will pay is determined by the patient's deductible, copay, co-insurance, and out of pocket limit amounts with their insurance company.

Deductible: Most insurance policies are written with a deductible. The deductible is the amount that the patient must pay before the insurance company is responsible. Sometimes the deductible is figured on a per-person basis with a maximum amount per year for the family.
The deductible may apply to all charges, or it may apply only to office visit charges and exclude exams, x-rays, and diagnostic procedures. The services that are subject to the deductible are decided by the insurance contract or policy. The amount of the deductible will differ from one company and one contract to another.

Copay & Co-insurance amounts: A *copay* is a **set dollar amount** that the patient is responsible for. With a ***co-insurance*** the patient is responsible for a **percentage of the allowed amount** on a service. Some insurance contracts will have the patient responsible for a combination of a copay and a co-insurance on charges, or may utilize a copay for certain services and a co-insurance for others.

To help you understand your payment responsibility, our staff will be happy to check your benefits. **However, a quote of benefits by our staff does not guarantee payment by your insurance company or verify eligibility.** Benefits may be **exhausted** *or* **denied** for various reasons. In this instance, **Valente Chiropractic holds no liability for patients' accrued charges.** Should your health insurance company deny payment, you are personally and fully responsible for your charges. It is for this reason that we **highly recommend** that you contact your insurance company to discuss your benefit coverage for chiropractic and massage services when provided by our practitioners.

Valente Chiropractic is pleased to offer **EVERYONE** a **time of service (TOS) discount.**

A Time of Service Discount is a discount off of our standard fee schedule. This discount is available when making payment at the time that service is rendered. Payment can be made via check, cash, or credit card.

There are many administrative costs and extra tasks that must be completed when processing insurance claims and sending statements to patients. A patient paying at the time of service greatly lessens this workload which allows us to pass significant savings on to both the patient and their insurance company for those patients who submit their own claims to the insurance company for reimbursement. Please see the chart on the following page of this packet for examples of our standard fee and TOS discount fee on some of our most common services.

Patient initial here: _____

Valente Chiropractic Fee Schedule

Please note that this list only includes some of our most common charges and is not a complete copy of our fee schedule. A complete copy can be obtained on request. **Fee schedule last updated March 1st, 2021.**

Service	Standard Fee	Time of Service Fee
Chiropractic Adjustment		
98940 1 to 2 region Adjustment – When the doctor adjusts 1 to 2 areas of your spine. For example: your neck and your upper back.	$50.00	$35.00
98941 3 to 4 region Adjustment – When the doctor adjusts 3 to 4 areas of your spine. For example: your neck, middle back, and lower back.	$70.00	$48.00
98943 Extremity Adjustment – Adjustments of the Shoulders, Elbows, Knees, Feet or other non spinal regions.	$32.00	$20.00
Massage		
97124 Massage Therapy 1 hour (4x - $36.00 per unit)	$144.00	$76.00
Rehab & Other Modalities		
97110 Exercises	$50.00	$35.00
97139 Kinesio Taping, Epley's Maneuver (virtigo), & other therapies	$43.00	$30.00
97140 Trigger Point Therapy, Graston Technique, Manual Therapy Techniques	$36.00	$25.00
97012 Mechanical Traction, Saunders Cervical Traction, Lumbar Traction	$26.00	$18.00
Exam (New patient / patient that hasn't been seen in over 3 years)		
99202 Level II Exam	$120.00	$85.00
99203 Level III Exam	$170.00	$120.00
Please note that there are 4 levels of examination and that the level of exam that you receive is determined by the doctor. His determination is based on a variety of factors, including but not limited to, the severity of your condition along with the information, tests and time necessary to appropriately assess your condition and plan your care.		
Re-Exam		
99212 Level II Re-Exam	$75.00	$52.00
99213 Level III Re-Exam	$120.00	$85.00
Radiology		
72040 2 or 3 View Cervical X-Rays (neck)	$72.00	$55.00
72070 2 View Thoracic X-Rays (upper/mid back)	$72.00	$55.00
72100 2 View Lumbar Sacral X-Rays (low back)	$72.00	$55.00

Dr. Valente believes communication is essential in the doctor-patient relationship. He invites you to feel free to privately discuss any financial concerns or difficulties you may have regarding your account. Early and open communication in these situations affords everyone the opportunity to reach a resolution suitable to all parties.

By signing below, I agree to the following: "I have read, understand, and agree with the described financial policies on this and the preceding page. By signing I agree that I also understand that as the patient, or legal guardian of the patient, I am ultimately personally responsible for any and all costs associated with the course of my treatment and care at Valente Chiropractic. Failure to pay all costs associated with my care as agreed may result in collection activity on my account as well as reporting of my payment history to credit reporting bureaus."

_____ _____

Patient Name (Please Print) Date

X_____.

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE

VALENTE
CHIROPRACTIC

Massage Therapy Agreement

- I hereby authorize the release of medical information necessary to process my charges or insurance claims. This may include intake forms, chart notes, reports, correspondences, billing statements and any other information to my attorney(s), health care provider(s), insurance compan(ies) and case manager(s).

- I am responsible for all charges for all services provided. In the event that the insurance company denies benefits or makes a partial payment, I am responsible for any balance due.

- I understand the benefits and risks of massage and give my consent for massage. I will consult my practitioner with any questions or concerns immediately.

- I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes.

No Show and Cancellation Fees:

- I understand that I will be charged and agree to pay a $25 cancellation fee if I don't show up for my massage appointment or cancel the same day or the business day prior to the appointment.

- I understand that I will be charged and agree to pay a $70 cancellation fee if I didn't show for or canceled the same or prior business day over 3 massage appointments.

- I understand I will be charged and agree to pay a $12.50 late fee if I'm more than 15 minutes late to my massage appointment.

Patient Name: _____

Signature: _____ Date: _____