# Kapeikis Chiropractic & Massage, P.S.

***"Active Care for Active Lifestyles"***

630 N. Chelan Ave. Ste.  B-2, Wenatchee, WA 98801, phone: 509-665-8363, fax: 509-662-7274

Thank you for choosing Kapeikis Chiropractic & Massage, P.S.

You have opened the intake packet indicating you are

**A RETURNING PATIENT WITH A NEW COMPLAINT or INJURY**

If your symptoms are related to a CAR ACCIDENT, WORK INJURY, or THIRD PARTY LIABLE INJURY please go back and find the appropriate "intake packet".

Please print the following pages, fill out what is relevant to your current symptoms and bring the completed forms with you to your appointment.

Thank you for taking the time to help us provide appropriate and efficient care for you.

Sincerely,
Paul Kapeikis, D.C.

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Phone (509) 665-8363, Fax (509) 662-7274

**PATIENT INFORMATION** **DATE:**________________

Last name:__________________________ First name:______________________ Middle:________

Address:________________________________ City/State:____________________ Zip Code:______

Social Security number_______________________________________ Age:_________

Date of Birth:______________________ Gender:_________ Marital Status:______________

If patient is a minor, name of parent/guardian:____________________________________

Home Phone:________________________ Cell Phone:___________________________

Employer:___________________________________

Occupation:________________________________

Business Phone:______________________ Email Address:__________________________________

Kapeikis Chiropractic and Massage Clinic will occasionally email updates and special discounts. If you prefer not to receive emails, please let our office know.

Emergency Contact: Name:_____________________________________ Phone:_________________

**BILLING AND INSURANCE INFORMATION**

Primary Medical Insurance Company:__________________________________________________

Name of Insured on policy:___________________________________________________________

Insured's Date of Birth:________________ Insured's employer:________________________________

Insured's address (only if different than patient):___________________________________________

Do you have a referral?: ____Yes _____ No Do you need preauthorization?: ____Yes _____ No
(A referral and/or preauthorization may be required by your insurance company for coverage and payment)

Referring Physician:_____________________________________ Phone:________________

**Are you seeking treatment as a result of an accident or injury? ____Yes _____ No**

Date of Injury:__________________ Claim Number:___________________________________

Name of insurance:____________________________ Policy number:_________________________

Claim manager name and phone number:_______________________________________________

Have you retained an attorney?: ____Yes _____ No Attorney Name:_________________________

## BILLING POLICY and AUTHORIZATION

Kapeikis Chiropractic and Massage Clinic will submit claims to your insurance company. Please contact your insurance company to ask about your specific coverage. An invoice for services rendered, will be mailed to the address you have provided above, each month. Payment is expected within 30 days of invoice date. Please be aware that your insurance provider may consider some, and perhaps all, of the services rendered not medically necessary. You will be responsible for these charges as well as any out of pocket expenses, deductibles, co-pays, and charges above reasonable and customary. You are responsible for reporting all changes immediately.

I have read and agree with the above billing policy and authorize payment of medical benefits directly to Kapeikis Chiropractic and Massage Clinic.

I authorize the release of my records to insurance and relevant health care providers for the purposes of collecting insurance payments and continuity of care.

I understand that I am ultimately responsible for full payment of all services received from Kapeikis Chiropractic and Massage Clinic, and for all expenses incurred in collecting a past due account.

Patient signature_____________________________________________Date:____________________

Parent/guardian signature of minor patient_________________________________________________

## MISSED APPOINTMENT POLICY

I understand that I will be charged $25.00 for CHIROPRACTIC, and $40.00 for MASSAGE appointments missed or cancelled with less than 24 hour advance notice.

Patient signature_____________________________________________Date:____________________

Parent/guardian signature of minor patient_________________________________________________

## CONSENT TO PARTICIPATE

Therapeutic procedures conducted in this office are considered safe and effective methods of care. As with any procedure intended to help, complications may arise. These complications include increased pain, swelling, bruising, muscle strain and discomfort, burns, lightheadedness, fainting or a temporary worsening of symptoms. More serious complications are extremely rare. Additional information concerning side-effects and complications is available upon request. **Your participation is voluntary.**

Patient signature_____________________________________________Date:____________________

Parent/guardian signature of minor patient_________________________________________________

## Acknowledgement of receipt of NOTICE OF PRIVACY PRACTICES

Patient signature_____________________________________________Date:____________________

Parent/guardian signature of minor patient_________________________________________________

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This is our **Notice of Privacy Practices for Protected Health Information**. It describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

## Your Rights

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

| | |
|---|---|
| **Get an electronic or paper copy of your medical record** | You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.<br>•We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee. |
| **Ask us to correct your medical record** | • You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.<br>• We may say "no" to your request, but we'll tell you why in writing within 60 days. |
| **Request confidential communications** | • You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.<br>• We will say "yes" to all reasonable requests. |
| **Ask us to limit what we use or share** | • You can ask us not to use or share certain health information for treatment, payment, or our operations.<br>• We are not required to agree to your request, and we may say "no" if it would affect your care.<br>• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.<br>• We will say "yes" unless a law requires us to share that information. |
| **Get a list of those with whom we've shared information** | • You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.<br>• We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months. |
| **Get a copy of this privacy notice** | • You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. |
| **Choose someone to act for you** | • If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.<br>• We will make sure the person has this authority and can act for you before we take any action. |
| **File a complaint if you feel your rights are violated** | • You can complain if you feel we have violated your rights by contacting us using the information on page 1.<br>• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.<br>• We will not retaliate against you for filing a complaint. |

## Your Choices

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

| | |
|---|---|
| **In these cases, you have both the right and choice to tell us to:** | • Share information with your family, close friends, or others involved in your care<br>• Share information in a disaster relief situation<br>• Include your information in a hospital directory<br>• Contact you for fundraising efforts<br>*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.* |
| **In these cases we *never* share your information unless you give us written permission:** | • Marketing purposes<br>• Sale of your information<br>• Most sharing of psychotherapy notes |
| **In the case of fundraising:** | • We may contact you for fundraising efforts, but you can tell us not to contact you again. |

# Our Uses and Disclosures

**How do we typically use or share your health information?** We typically use or share your health information in the following ways.

| | |
|---|---|
| **Treat you** | • We can use your health information and share it with other professionals who are treating you.<br>***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.* |
| **Run our organization** | • We can use and share your health information to run our practice, improve your care, and contact you when necessary.<br>***Example:*** *We use health information about you to manage your treatment and services.* |
| **Bill for your services** | • We can use and share your health information to bill and get payment from health plans or other entities.<br>***Example:*** *We give information about you to your health insurance plan so it will pay for your services.* |

**How else can we use or share your health information?** We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.

| | |
|---|---|
| **Help with public health and safety issues** | We can share health information about you for certain situations such as:<br>• Preventing disease<br>• Helping with product recalls<br>• Reporting adverse reactions to medications<br>• Reporting suspected abuse, neglect, or domestic violence<br>• Preventing or reducing a serious threat to anyone's health or safety |
| **Do research** | • We can use or share your information for health research. |
| **Comply with the law** | • We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law. |
| **Respond to organ and tissue donation requests** | • We can share health information about you with organ procurement organizations. |
| **Work with a medical examiner or funeral director** | • We can share health information with a coroner, medical examiner, or funeral director when an individual dies. |
| **Address workers' compensation, law enforcement, and other government requests** | We can use or share health information about you:<br>• For workers' compensation claims<br>• For law enforcement purposes or with a law enforcement official<br>• With health oversight agencies for activities authorized by law<br>• For special government functions such as military, national security, and presidential protective services |
| **Respond to lawsuits and legal actions** | • We can share health information about you in response to a court or administrative order, or in response to a subpoena. |

# Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

**Changes to the Terms of This Notice**
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective date of this message 1/1/2015
Contact Kapeikis Chiropractic & Massage (509) 665-8363 kapeikis@nwi.net

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## We haven't seen you in a while and need to know if any of your information has changed.

**Name:** ______________________________________________ **Date:** ____/____/____

**Home Address:** ____________________________________ **City:** ____________________

**State:** ______ **Zip:** ____________ **Telephone Number:** ________________ **Cell:** ________________

**Email:** ___________________________________________

**Parent or Spouse:** _________________________________________________

**Emergency Contact** __________________________________________ **Phone #** ________________

## ACCOUNT INFORMATION

**Have you changed your MEDICAL INSURANCE in any way. If so, please notify the receptionist and be prepared to PROVIDE CURRENT MEDICAL CARD and information.**

## HEALTH STATUS

***SINCE YOUR LAST VISIT*:**

1. **Physical injuries: severe sprains, strains, broken bones?** __________________________________

   ________________________________________________________________________________

2. **Surgical procedures:** ____________________________________________________________

   ________________________________________________________________________________

3. **Changes in medications:** _________________________________________________________

4. **Illnesses requiring hospitalization or extended medical care:** ______________________________

   ________________________________________________________________________________

5. **Have you recently experienced any of the following:**

| | |
|---|---|
| **Fever** | **Nausea** |
| **Fainting** | **Dizziness** |
| **Shortness of Breath** | **Unexplained Extreme Fatigue** |
| **Rapid or Skipping Heart Beat** | **Severe Constipation Diarrhea** |
| **Cloudy, Bloody, Sweet or Unusual Smelling Urine** | **Unexplained Weight Loss or Gain.** |
| **Bloody, Black or Consistently Narrowed Stool** | **New Allergies** |

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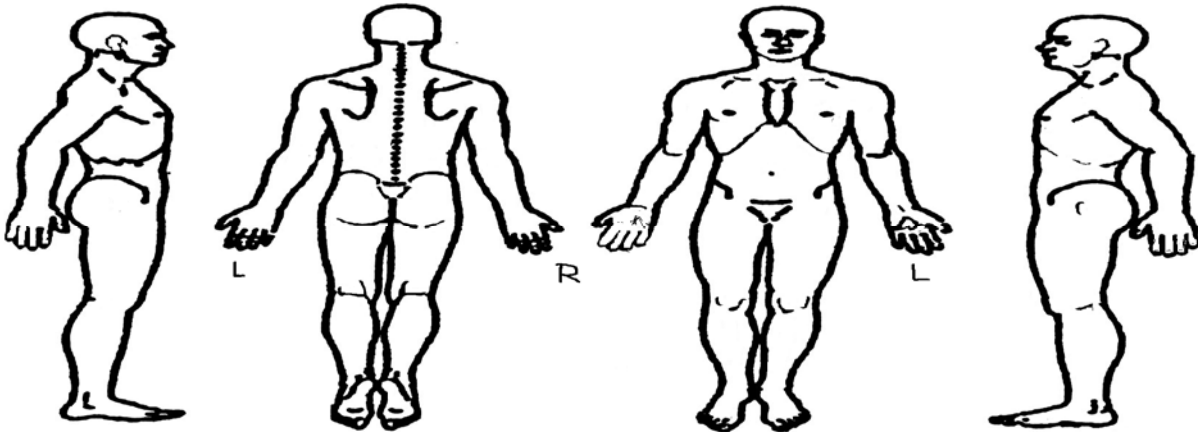
**Name**: ____________________ **Date of Birth**: __________ **Today's Date**: __________

# NEW COMPLAINT

***Please fill out a SEPARATE FORM FOR EACH COMPLAINT***

1. **My Complaint is:** Headaches Jaw Neck Upper Back L Shoulder R L Elbow R L Wrist R L Hand R Mid Back Low Back L hip R L Knee R L Ankle R L Foot R Other: ______________________
2. **This problem first began/noticed on**: ______________________ (***Date Required for Insurance***)
3. **How did this problem start/mechanism of injury:** ______________________ ______________________ (***Required for Insurance***)
4. **Please indicate on the drawings where you notice your symptoms**. **Please indicate the quality of these symptoms**: SS=sharp stabbing, DD= dull diffuse, A= aching, B=burning, St= stiffness, Nb= numbness, T= tingling, CR= cramping, El= electrical "zingers". **Please feel free to add your own description including radiation or referral of your symptoms.**




(0 is no pain/symptoms -10 is unbearable pain/symptoms)

5. **Please indicate the severity of symptoms right now:** 0 - 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
6. **How often do you experience these symptoms?**
   Constant (76-100% of the time) Frequent (51-75% of the time) Occasional (26-50% of the time) Intermittent (1-25% of the time)
7. **What aggravates these symptoms?** ______________________
8. **What is the worst these symptoms have been?** 0 - 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
9. **What alleviates these symptoms?** ______________________
10. **What is the best these symptoms have been?** 0 - 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
11. **How are these symptoms interfering with your normal activities?** ______________________ ______________________
12. **Have these symptoms changed with time?** Getting Worse Staying the Same Getting Better
13. **Has any other health care provider addressed this complaint?** No Yes: ______________________