



**SNOHOMISH FAMILY CHIROPRACTIC**  
**112 AVENUE D, SUITE A, SNOHOMISH, WA 98290**  
**TEL: (360) 863-2412 EMAIL: [DrMorganBinnie@gmail.com](mailto:DrMorganBinnie@gmail.com)**  
**[WWW.SNOHOMISHFAMILYCHIROPRACTIC.COM](http://WWW.SNOHOMISHFAMILYCHIROPRACTIC.COM)**

#### PATIENT INFORMATION

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home/Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: ☐ Male ☐ Female  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
How were you referred to Snohomish Family Chiropractic? \_\_\_\_\_  
☐ Family Member ☐ Friend ☐ Doctor ☐ Other: \_\_\_\_\_  
Please give us the name of the family member, friend, or doctor that referred you \_\_\_\_\_

#### In event of an Emergency

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_ Cell#: \_\_\_\_\_ Work#: \_\_\_\_\_

#### INSURANCE INFORMATION

Auto Accident ☐ Yes ☐ No Date of Accident: \_\_\_\_\_ Claim #: \_\_\_\_\_  
Private Insurance: \_\_\_\_\_ Self Pay (not submitting to insurance) \_\_\_\_\_ Medicare: \_\_\_\_\_  
Primary Insurance Company: \_\_\_\_\_  
ID#: \_\_\_\_\_ Group#: \_\_\_\_\_ Phone#: \_\_\_\_\_  
Address: \_\_\_\_\_

I hereby state that the information on this form is true and correct. I authorize Dr. Morgan Binnie to examine, take x-rays and treat for the care and management of my condition in accordance with the state statutes. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. Morgan Binnie will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any authorized to be paid, be paid directly to Snohomish Family Chiropractic, LLC which will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible to payment. I also understand that if I suspect or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I hereby authorize the release of my health evaluation, examination, prognosis, and treatment records to my employer, attorney, or insurance company. Please notify office staff if you have any questions or concerns regarding this Office Policy Statement. If you are in agreement with this statement, please sign and date below.

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

Briefly describe your current symptoms? \_\_\_\_\_

When did your symptoms start? \_\_\_\_\_

Is your current injury/condition related to an auto/ work accident? ☐ Yes ☐ No

If yes, what is the date of accident? \_\_\_\_\_

Please mark the location where you have the pain or other symptoms.

**Please describe your symptom(s).**

☐ Sharp ☐ Dull Ache ☐ Numb ☐ Shooting

☐ Burning ☐ Tingling ☐ Other \_\_\_\_\_

**Since your symptom(s) began, are they ...**

☐ Increasing ☐ Decreasing ☐ Not changing

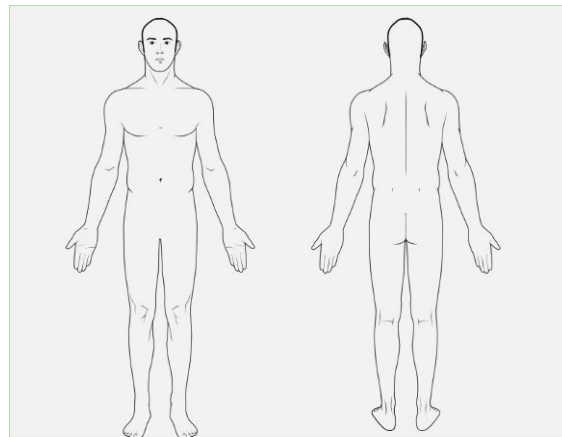
**How often do you experience your symptom (s)?**

☐ Constantly (76% - 100%) ☐ Frequently (51% - 75%)

☐ Occasionally (26% - 50%) ☐ Intermittently (0% – 25%)

**If anything, what makes this better?** \_\_\_\_\_

**If anything, what makes this worse?** \_\_\_\_\_



None

Unbearable

Rate the severity of your pain in the last 24 hours

0 1 2 3 4 5 6 7 8 9 10

0 1 2 3 4 5 6 7 8 9 10

**How much have your symptoms interfered with your usual daily activities?** (outside the home & housework)

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

**How is your condition changing, since care began at this facility?**

☐ N/A – this is the initial visit ☐ Much Worse ☐ Worse ☐ A little worse

☐ No Change ☐ A little better ☐ Better ☐ Much Better

**In general, would you say your overall health right now is ...**

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Please list any other health care providers consulted for this condition.

**Past Chiropractic Care?** ☐ Yes ☐ No Dr. Name/Location: \_\_\_\_\_

**Women:** Are you or is there a possibility that you may be pregnant? \_\_\_\_\_

If yes, what is your due date? \_\_\_\_\_

For Office use only:

DX Codes: \_\_\_\_\_

Please indicate if you have or presently have any of the following conditions:

**Cardiovascular**

☐ Fainting                      ☐ Heart Disease                      ☐ High/Low Blood Pressure                      ☐ Irregular Heartbeat                      ☐ Phlebitis  
☐ Poor Circulation                      ☐ Swelling of Hands/Feet                      ☐ Swelling of Legs                      ☐ Other: \_\_\_\_\_

**Ear/Nose/Throat**

☐ Dizziness                      ☐ Hearing Loss                      ☐ Sinus Infection                      ☐ Nose Bleed                      ☐ Sore Throat  
☐ Jaw Clicks                      ☐ Bleeding Gums                      ☐ Difficulty Swallowing                      ☐ Other \_\_\_\_\_

**Gastrointestinal**

☐ Nausea/Vomiting                      ☐ Liver Problems                      ☐ Constipation                      ☐ Diarrhea                      ☐ Ulcers  
☐ Black /Bloody Stools                      ☐ Gallbladder Problems                      ☐ Bowel Problems                      ☐ Other \_\_\_\_\_

**Musculoskeletal**

☐ Osteoporosis                      ☐ Arthritis                      ☐ Joint Stiffness                      ☐ Muscle Weakness                      ☐ Gout  
☐ Broken Bones                      ☐ Joints Replaced                      ☐ Other \_\_\_\_\_

**Respiratory**

☐ Asthma                      ☐ Bronchitis                      ☐ Cold/Flu                      ☐ Cough/Wheezing                      ☐ Emphysema  
☐ Difficulty Breathing                      ☐ Pneumonia                      ☐ Shortness of Breath                      ☐ Other \_\_\_\_\_

**Eyes**

☐ Glaucoma                      ☐ Double Vision                      ☐ Blurred Vision                      ☐ Color Blindness                      ☐ Cataracts  
☐ Glasses                      ☐ Eye Pain                      ☐ Poor Vision                      ☐ Other \_\_\_\_\_

**Genitourinary**

☐ Kidney Disease                      ☐ Burning Urination                      ☐ Frequent Urination                      ☐ Blood in Urine  
☐ Kidney Stone                      ☐ Lower Side Pain                      ☐ Other \_\_\_\_\_

**Neurological**

☐ Stroke                      ☐ Seizure                      ☐ Severe Headaches                      ☐ Numbness                      ☐ Head Injury  
☐ Pinched Nerve                      ☐ Carpal Tunnel                      ☐ Brain Aneurysm                      ☐ Other \_\_\_\_\_

**Hematologic/Lymphatic**

☐ Hepatitis                      ☐ Blood Clots                      ☐ Easy Bleeding                      ☐ Easy Bruising                      ☐ Cancer  
☐ Fever                      ☐ Chills                      ☐ Sweats                      ☐ Other \_\_\_\_\_

**Endocrine/Constitutional**

☐ Diabetes                      ☐ Thyroid Disorder                      ☐ Menstrual Problems                      ☐ Other \_\_\_\_\_  
☐ Weight Gain                      ☐ Weight Loss                      ☐ Difficulty Sleeping                      ☐ Other \_\_\_\_\_

Indicate if an *immediate* family member has had any of the following:

☐ Rheumatoid Arthritis                      ☐ Heart Problems                      ☐ Diabetes                      ☐ Lupus                      ☐ Stroke                      ☐ Other \_\_\_\_\_

Surgeries/ Hospitalizations: \_\_\_\_\_

Serious Illness or Injury: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications taken within the last two months (include over the counter and vitamins): \_\_\_\_\_

Habits: Caffeine (use/day) \_\_\_\_\_ Alcohol \_\_\_\_\_ Drugs (type/use/week) \_\_\_\_\_

Tobacco: Current Smoker (use/week): \_\_\_\_\_ Former Smoker, quit date: \_\_\_\_\_ Never Smoked \_\_\_\_\_

Are there any other issues concerning your health that you would like the doctor to be aware of? \_\_\_\_\_

Have you had any other significant traumas? (Auto Accidents, falls, etc.): \_\_\_\_\_

\_\_\_\_\_  
Patient Initials



## **HIPPA PRIVACY AUTHORIZATION FORM**

### **\*\* AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION \*\***

I authorize Dr. Morgan Binnie at Snohomish Family Chiropractic to keep record and disclose my health information in necessary circumstances. Necessary circumstances would include:

- Disclosing your health information to another trusted healthcare provider in regards to verifying treatment and/or x-rays.
- Disclosing your healthcare information to another trusted healthcare provider in regards to referrals for continuing treatment.
- Disclosing your healthcare information and billing records to a trusted party if they become responsible of payment we can't obtain.
- Disclosing your healthcare information in the office with current employees for quality control and operational purposes.
- Disclosing your healthcare information to your insurance company.

#### Your right to limit use or disclosure

You have the right to request that we do not disclose any information to specific individuals, companies, organizations in legal parameters. If you would like us to place any restrictions on your health information, please provide us with a written and signed letter. We are not required to agree to your request if legal parameters are not met.

#### Your right to revoke your authorization

You may revoke your consent to us at any time in writing. We will not be able to honor your request if we receive it after your health information has already been sent for any of the reasons listed above.

I have read this policy agreement, asked for clarification if needed, and agree to these terms.

Printed Patient Name: \_\_\_\_\_

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

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

Printed Guardian Name: \_\_\_\_\_

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

*Snohomish Family Chiropractic*

*112 Avenue D, Suite A, Snohomish, WA 98290 Tel: (360) 863-2412 Email: DrMorganBinnie@gmail.com*



## OFFICE FINANCIAL POLICY

We are committed to providing exceptional chiropractic care for our patients and strive to make our services affordable for you. We are pleased to offer these payment options for you.

CASH / CHECK	HSA / VISA / MASTERCARD
--------------	-------------------------

### Cash Patients

Payment is expected at time of service for any treatment provided, unless prior arrangements have been made and a payment plan arrangement has been signed. For your convenience, we accept cash, check, HAS, Visa, Mastercard and American Express.

### Insurance patients

As a courtesy to you, we will file your insurance claim on your behalf after every appointment. We will do our best to estimate what your patient portion will be after insurance has paid if needed. For any amount that is left after insurance has paid, regardless of the estimate, will be patient portion and responsibility to provide payment.

***\*\* For any questions about payments or payment plans, please do not hesitate to ask! We are here to help! \*\****

I agree that I have read the office financial policy for Snohomish Family Chiropractic and understand that I am fully responsible for any patient portion due to any matter listed above. I understand that any unpaid service is due within 90 days of service date.

Print Patient Name: \_\_\_\_\_ Print Guardian Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Guardian Signature: \_\_\_\_\_

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



## **Cancellation/No Show Policy/No Show Policy for Doctor Appointments**

### **1. Cancellation/ No Show Policy for Doctor Appointment.**

a) We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel, and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. If an appointment is not cancelled at least 12 hours in advance you will be charged a ten-dollar (\$10) fee; this will not be covered by your insurance company and we will use the credit card that you have on file with our office to automatically charge said fee.

b) If you fail to cancel or reschedule your appointments by the third (3<sup>rd</sup>) missed appointment with no cancellation 12 hours in advance you will be charged a twenty dollar (\$20) fee; this will not be covered by your insurance company and we will use the credit card that you have on file with our office to automatically charge said fee.

### **2. Scheduled Appointments**

We understand that delays can happen however we must try to keep the other patients and doctors on time. If a patient is 15 minutes past their scheduled time, we will have to reschedule the appointment.

\_\_\_\_\_  
Print Name Patient

\_\_\_\_\_  
Signature Patient/Guardian

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

*Snohomish Family Chiropractic*  
112 Avenue D, Suite A, Snohomish, WA 98290 Tel: (360) 863-2412 Email: [DrMorganBinnie@gmail.com](mailto:DrMorganBinnie@gmail.com)