



X-Ray Patient Consent Form

Patient Consent to X-Ray

I authorize the performance of diagnostic x-ray examination of myself which Dr. William Warburton may consider necessary or advisable in the course of my examination and treatment.

Signed _____ Date _____

If Patient is a Minor

I am the parent or legal representative of _____ who is a minor, _____ years of age. I authorize the performance of diagnostic x-ray of this minor which Dr. William Warburton may consider necessary or advisable.

Signed _____ Date _____

Females: Regarding Possibility of Pregnancy

This is to certify that, to the best of my knowledge, I am not pregnant, and Dr. William Warburton has my permission to perform diagnostic x-ray examination. I have been advised that certain x-ray examinations, particularly those involving the pelvis, can be hazardous to an unborn child.

Signed _____ Date _____



mercer wellness
chiropractic

Fee Schedule
for
Chiropractic Care and Massage Therapy

New Patient Exams (depending upon level of exam)	\$65. ⁰⁰ - \$150. ⁰⁰
Chiropractic Manipulation Therapy CMT (depending on # of Regions)	\$35. ⁰⁰ - \$55. ⁰⁰
Diagnostic X-Rays (depending on # of Views)	\$80. ⁰⁰ - \$180. ⁰⁰
Therapeutic Activities	\$35. ⁰⁰
Therapeutic Exercises	\$35. ⁰⁰
Mechanical Traction	\$30. ⁰⁰
Myofascial Release	\$30. ⁰⁰
1 Hour Massage Therapy	\$70. ⁰⁰
1 ½ Hour Massage Therapy	\$105. ⁰⁰

*Not ALL services are listed.

These are the amounts billed to your insurance. Payment plans are available for those who have little or no insurance coverage for chiropractic care and massage therapy. These amounts are determined by the usual and customary fee schedule for chiropractors in Seattle and the Greater Eastside area.

I have read and accept Mercer Wellness Chiropractic's Fee Schedule.

Print Your Name:

Signed:

Dated:



We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the PRIVACY PRACTICE NOTICE that has been provided to you before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operation, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Print Name

Signature

Date



CONFIDENTIAL CASE HISTORY

Date: _____

Name: _____

Male

Female

DOB: ____/____/____

Height: _____

Avg. Weight: _____

PAST MEDICAL HISTORY: None
(List all serious illnesses/injuries with places and dates.)

PAST SURGICAL HISTORY: None
(List all operations with places and dates.)

Check any of the symptoms you have noticed:
(= Previous = Now)

- Headaches
- Dizziness or light-headed
- Jaw pain, clicking or locking
- Pain or difficulty swallowing
- Neck pain or stiffness
- Shoulder pain
- Mid-back pain
- Chest pain or cough
- Pain/Trouble breathing
- Arm/Hand numbness/tingling
- Arm/Hand fatigue/weakness
- Low back pain
- Leg/Foot numbness/tingling
- Leg/Foot fatigue/weakness
- Leg pain with walking
- Abdominal pain
- Nausea or vomiting
- Diarrhea or constipation
- Blood in urine or stool
- Difficulty or pain w/ urination
- Difficulty with sexual function
- Abnormal menstrual periods
- Sensitive to light or sound
- Visual or hearing disturbance
- Memory loss/problems
- Irritability or depression
- Fatigue or loss of energy
- Fainting or convulsions
- Trouble with balance or coordination
- Sleep disturbances/problems
- Rashes (face, body, limbs)
- Joint pain or swelling
- Pain with exertion (activity, climbing stairs, etc.)

CURRENT MEDICATIONS & OTC None
(Reason Used)

SOCIAL HISTORY:

Cigarette Smoking: Now Former Never
Packs/day _____ How long? _____ Quit Date: _____

Do you drink alcohol? Yes No
Drinks per week _____

Exercise Habits? Frequent Occasional Never

Job History: _____

If female, are you possibly pregnant? Yes No

Are you married? Yes No Military? Yes No

HEALTH MAINTENANCE:
(When did you last have the following?)

General Check-up: _____

Pap Smear/Female Exam: _____

Mammogram: _____

Date of last Menstrual Cycle: _____

Have you ever been under chiropractic care?
 Yes No

FAMILY HISTORY:

	YES	NO
Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>
Spine Surgery.....	<input type="checkbox"/>	<input type="checkbox"/>

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to exam and treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complication, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by patient:

Print Your Name

X _____
Signature Date

If patient is a minor or physically or legally incapacitated. To be completed by patient's representative:

Print Name of Patient

Print Name of Patient's Representative

Signature of Patient's Representative

As: _____
Relationship or authority of Patient's Representative

Date

To be completed by doctor or staff:

Bill Warburton DC
7605 SE 27th St SE Suite 103
Mercer Island, WA 98040

Name of doctor treating this patient:

Bill Warburton, DC

Witness to Patient's Signature

Date