



## PATIENT APPLICATION FORM

*Welcome and Thank you for applying as a patient in our clinic.*

We are a very unique team specializing in researched-based spinal and postural rehabilitation. These methods have enabled our patients to achieve their optimal health; even when many other systems have failed. Because of this specialized approach, we may not accept you as a patient until we are absolutely certain we know the cause of your condition, that we can perform the necessary tests to establish an optimal rehab program for you, and are completely confident we can help you recover your health. Please know if we do accept you as a patient, we will then make specific recommendations based upon our understanding that your health will become your TOP PRIORITY. Thank you again for applying as a patient in our clinic.

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**Patient name**

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**Date Completed**

## Patient Information

Name: \_\_\_\_\_ (Age) \_\_\_\_\_ Gender: M F  
Home Address: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_  
Email Address: \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_  
Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Marital Status: S M D W  
Occupation: \_\_\_\_\_ Employer Name: \_\_\_\_\_  
Spouse's Name: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_  
Spouse's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
How were you referred to this office? \_\_\_\_\_

## Purpose For This Visit

Reason for this visit: \_\_\_\_\_

Is this related to an accident or specific injury (other than auto or work-related)\*?  Yes  No If yes, when: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

*\*If your symptoms are the result of an auto accident or work-related injury, please ask the front-desk person for the corresponding application.*

Describe: \_\_\_\_\_

**Please use the *General Symptoms Chart* on the next page to provide a detailed notation of your symptoms.**

When did these symptoms begin? \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Are they:  Constant  Intermittent  Activity-related

Are they getting worse?  Yes  No Do they interfere with:  Work  Sleep  Hobbies  Daily Routine

Explain: \_\_\_\_\_

What activities aggravate your symptoms? \_\_\_\_\_

Is there anything that relieves your symptoms?  Yes  No If yes, explain: \_\_\_\_\_

Have you experienced these symptoms before (if not accident/injury related)?  Yes  No

If yes, explain: \_\_\_\_\_

Have you been treated for this?  Yes  No When were you last treated? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Who did you see? \_\_\_\_\_

What treatment was performed? \_\_\_\_\_

How did you respond? \_\_\_\_\_

## Experience with Chiropractic

Have you seen a Chiropractor before?  Yes  No Who? \_\_\_\_\_

Reason for visit(s): \_\_\_\_\_

Did your previous chiropractor take 'before' and 'after' x-rays?  Yes  No What was the diagnosis? \_\_\_\_\_

Did he or she recommend a specific course of treatment?  Yes  No Did they recommend a Home Health Care program?  Yes  No

If yes, what? \_\_\_\_\_ How long were you treated? \_\_\_\_\_ Last treatment: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

How did you respond? \_\_\_\_\_

Are you aware of any poor posture habits?  Yes  No Is there any history of spinal problems in your family?  Yes  No

If yes, explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## GENERAL SYMPTOMS CHART

Please use the following notations on the figures below to indicate the type and location of your symptoms, as it relates to the purpose of your visit today.

A = ACHE

B = BURNING

P = PINS & NEEDLES

G = STABBING

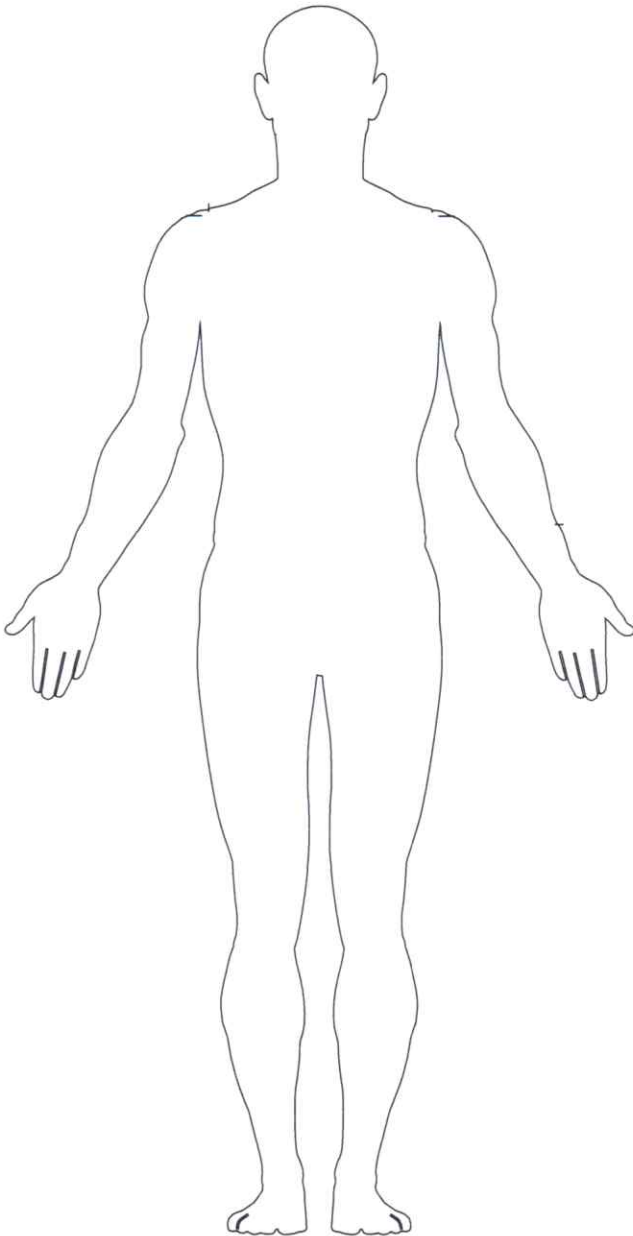
M = SPASMS

F = STIFFNESS

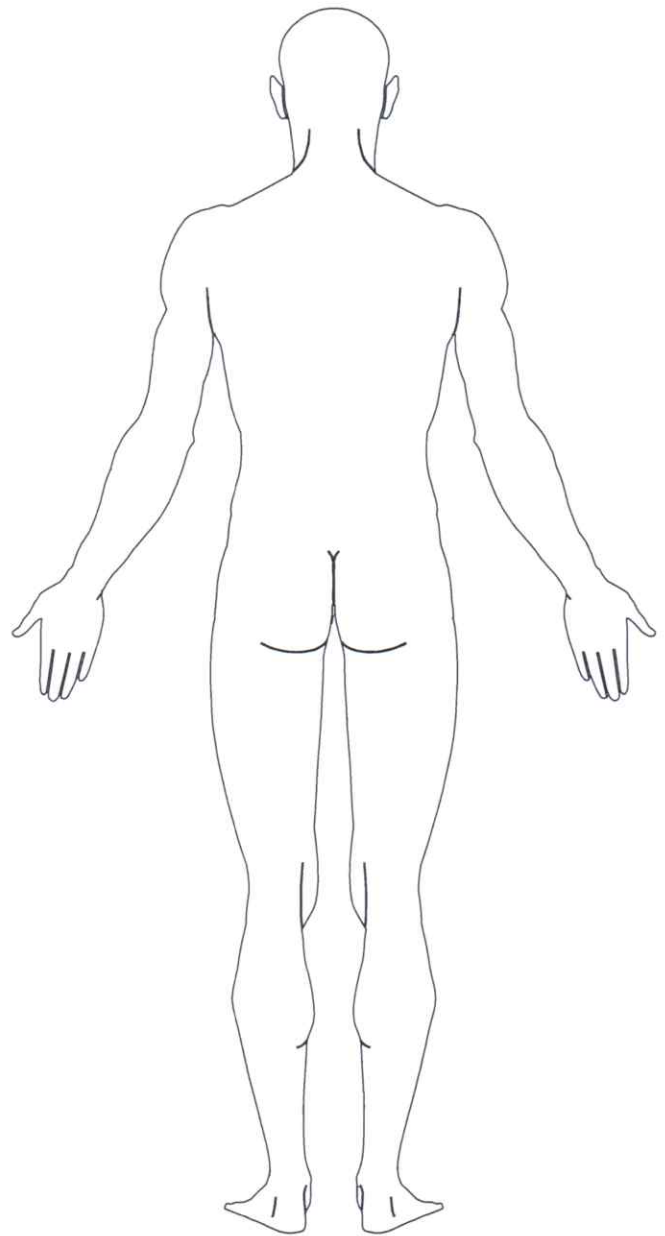
N = NUMBNESS

T = TINGLING

O = OTHER



**FRONT**



**BACK**

If you marked "O" for Other on any part, please explain below:

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## Health & Lifestyle

Do you exercise?  Yes  No How often? \_\_\_\_\_ day(s) per week; Other: \_\_\_\_\_

What activities?  Walking  Running/Jogging  Weight Training  Cycling  Yoga  Pilates  Swimming  Other: \_\_\_\_\_

Do you smoke?  Yes  No How much? / How often? \_\_\_\_\_

Do you drink alcohol?  Yes  No How much? / How often? \_\_\_\_\_

Do you drink coffee?  Yes  No How much? / How often? \_\_\_\_\_

Do you take any supplements (i.e. vitamins, minerals, herbs)? \_\_\_\_\_

If yes, please list: \_\_\_\_\_

## Health Conditions

Your spine is the foundation of health and core strength in your body. Shifts in the vertebrae or sections of the spine will spread ultimately causing weakness and distortion to ALL the areas of the spine. These distortions are reflected in abnormal posture. Research shows abnormal posture leads to chronic pain, disease and possibly a shortened life span.<sup>1</sup> Please answer the following questions accurately so we may determine the full extent of your condition.

### CERVICAL SPINE (NECK)

Misalignment of the individual vertebrae or distortion of the complete cervical curve (neck) originating in the neck or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

**Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.**

___ Neck Pain	___ Headaches	___ Sinusitis
___ Pain in shoulders/arms/hands	___ Dizziness	___ Allergies/Hay fever
___ Numbness/tingling in arms/hands	___ Visual disturbances	___ Recurrent colds/Flu
___ Hearing disturbances	___ Coldness in hands	___ Low Energy/Fatigue
___ Weakness in grip	___ Thyroid conditions	___ TMJ/Pain/Clicking

Please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### THORACIC SPINE (UPPER BACK)

Misalignment of the individual vertebrae or distortion of the upper thoracic curve (upper back) originating in the upper back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

**Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.**

___ Heart Palpitations	___ Recurrent Lung Infections/Bronchitis
___ Heart Murmurs	___ Asthma/Wheezing
___ Tachycardia	___ Shortness Of Breath
___ Heart Attacks/Angina	___ Pain On Deep Inspiration/Expiration

Please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

1. Postural and Degenerative Kyphosis: Freeman JT. Posture in the Aging and Aged body. JAMA 1957, Oct 19: 843-846.

## Health Conditions *continued...*

### THORACIC SPINE (MID BACK)

Misalignment of the individual vertebrae or distortion of the mid thoracic curve (mid back) originating in mid back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

**Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Mid Back Pain   | <input type="checkbox"/> Nausea           | <input type="checkbox"/> Diabetes                   |
| <input type="checkbox"/> Pain in Ribs/Chest  | <input type="checkbox"/> Ulcers/Gastritis | <input type="checkbox"/> Hypoglycemia/Hyperglycemia |
| <input type="checkbox"/> Indigestion/Heartburn   | <input type="checkbox"/> Reflux           |   |
| <input type="checkbox"/> Tired/Irritable after eating or when not having eaten for a while |   |   |

Please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### LUMBAR SPINE (LOW BACK)

Misalignment of the individual vertebrae or distortion of the lumbar curve (low back) originating in the low back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

**Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Pain in hips/legs/feet         | <input type="checkbox"/> Weakness/injuries in hips/knees/ankles      | <input type="checkbox"/> Low back pain         |
| <input type="checkbox"/> Numbness/tingling in legs/feet | <input type="checkbox"/> Recurrent bladder infections                | <input type="checkbox"/> Coldness in legs/feet |
| <input type="checkbox"/> Frequent/difficulty urinating  | <input type="checkbox"/> Muscle cramps in legs/feet                  | <input type="checkbox"/> Sexual dysfunction    |
| <input type="checkbox"/> Constipation/Diarrhea          | <input type="checkbox"/> Menstrual irregularities/cramping (females) |  |

Please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### OTHER

Please list any health conditions not mentioned: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any medications (include name, dose, for what condition, and how long you've been taking it): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any surgeries (include type of surgery and date it was performed): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Family Health History

Have any of your family members ever been diagnosed with the following (*please indicate "Y" for You, and "O" for Other than you, or both if applicable*):

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Neurological Problems	<input type="checkbox"/> Lung Disease
<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Stroke	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Metal Implants	<input type="checkbox"/> Infectious Disease	<input type="checkbox"/> Gall Bladder
<input type="checkbox"/> Broken bones/fractures	<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Tonsillectomy	<input type="checkbox"/> Hernia
<input type="checkbox"/> Pneumonia/Bronchitis	<input type="checkbox"/> Polio	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Anemia
<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Chicken Pox/Shingles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Measles
<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Small Pox	<input type="checkbox"/> Influenza	<input type="checkbox"/> Pleurisy
<input type="checkbox"/> Blood Sugar Problems	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Eczema/Psoriasis	<input type="checkbox"/> Lumbago
<input type="checkbox"/> Other: _____			

## Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Authorization of Care

I authorize and agree to allow the doctor and/or his designated staff to work with my spine or the spine of the charge I represent through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal bio-mechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

The Doctor and/or his staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another healthcare practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the doctors and/or staff's specific recommendations at this clinic that I will not receive the full benefit from these programs; and that if I terminate my care prematurely that all fees incurred will be due and payable at that time.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient's Name Printed \_\_\_\_\_

If patient is a legal charge of limited capacity requiring guardianship for treatment, please complete the following:

Date Guardianship Awarded \_\_\_\_\_ County, State of Guardianship \_\_\_\_\_

I hereby authorize the doctor to administer care as deemed necessary to my charge as appointed to by the courts.

Guardian Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## In Case of Emergency

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Work Phone ( ) \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_

## Insurance

We may accept assignment of insurance benefits. By signing this policy, you agree to assign your insurance benefits to this clinic. In cases where benefits are not assignable or in any case where your benefit is processed directly to you regardless of assignment, you agree to submit any payments received along with the explanation of benefits to this clinic within 10 days of receipt unless you have paid for the services represented by said payment in full at the time of service. In no case will an assignment alleviate you of your obligation for payment of services received.

Your insurance plan is a contract between you and your insurance company. This clinic is not a party to that contract and therefore cannot modify the terms of that contract. Payment for treatment you receive from this clinic is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with the necessary billing information, assign your benefits to this clinic and agree to permit us to release the necessary medical information required to secure payment. In the event we do accept assignment of benefits we require that you provide a credit card with authorization to bill that account any balance or make other payment arrangements. We will make every effort to ensure that your insurance carrier properly processes your services for payment. In some circumstances we may require your assistance. If your insurance company has not paid your account in full within 60 days and you refuse to assist us in dealing with your carrier, the balance will be automatically be transferred to your credit card or the extended payment plan.

### *ITEMIZED RECEIPTS, aka. "SUPERBILLS"*

*Our fees and charges are based on the cost of doing business and providing patients with the highest quality of care possible. This office does not participate with any insurance provider or accept such an assignment. Patients are responsible for payment of any services provided. You will be given a receipt with a description of services received, more commonly referred as a "superbill", along with the related charges that you, in turn, can submit to your own insurance company for possible reimbursement, as well as retain for your personal records.*

### DECLARATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The doctor's office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

I understand there could be some services that my insurance company does not cover, if this is the case are you willing to pay for these services?  Yes  No

Patient's Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Signature of Person Authorizing Care (if different from patient):

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

Relationship to Insured \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Employer \_\_\_\_\_

**Primary Insurance Company** \_\_\_\_\_ Policy# \_\_\_\_\_

Address Phone # ( ) \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**Secondary Insurance Company** \_\_\_\_\_ Policy# \_\_\_\_\_

Address Phone # ( ) \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_



Dr. Nolan Deatherage  
3713 Rucker Ave. Everett, WA 98201  
Phone: 425-258-1300 Fax: 425-259-7240  
Aligneverett@gmail.com

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

Date of Birth \_\_\_\_\_

**PATIENT CONSENT TO X-RAY**

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

Signed \_\_\_\_\_ Date \_\_\_\_\_

**CONSENT TO X-RAY 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 examination of this child or ward which Dr. Deatherage may consider necessary or advisable in the course of examination or treatment.

Signed \_\_\_\_\_ Date \_\_\_\_\_

**FEMALES: REGARDING POSSIBILITY OF PREGNANCY**

This is to certify that, to the best of my knowledge, I am not pregnant, and Dr. Deatherage 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 \_\_\_\_\_





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Phone: 425-258-1300 Fax: 425-259-7240  
Aligneverett@gmail.com

## Cancellation and No-Show Policy

### 1. Cancellation and No-Show Policy for Adjustments

We understand that there are times when you must miss an appointment due to emergencies or obligations to work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. **As such, if an appointment is not cancelled 24 hours in advance, you will be charged a fifty dollar (\$50) fee.** We reserve the right to make exceptions for instances that are unavoidable but we ask that you communicate with us. Failure to do so will result in a late fee.

### 2. Scheduled appointments

We understand that delays can happen, however, we must try to keep other patients and the Doctor on time. In our office we use a block schedule. Please call us if you are running late so we can allow a patient who is scheduled in the block after yours to start early. If you do not call, we may need to reschedule your appointment or we may no longer have enough time to do extra therapies such as traction.

### 3. Cancellations and No-Show Policy for: Exams, & Report of Findings, x-ray appointments and Consultations

We offer a limited amount of appointment times for these types of visits. They are typically scheduled in advance and last minute cancellations or not showing up for your scheduled visit means this time slot cannot be filled by someone else. These visits range from 20-45 minutes long.

**If your appointment is not cancelled or rescheduled with at least 24 hours advanced notice, you will be charged a seventy-five dollar (\$75) fee.**

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_

In the event you incur no-show or cancellation fees, you will receive a statement in the mail. Any fees not paid within 30 days are subject to automatic charge to your credit card on file. A receipt for these charges will be emailed to you.



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### Family Members and Friends Involved in Patient Care

This form documents my request to allow family members and/or friends to be involved in verbal discussions regarding my health care. The people listed below may receive any verbal information needed to participate in my care or to help me make decisions. By signing this form, I permit the staff of Align Chiropractic to discuss information about me with the people listed below. This information may include diagnoses, exam and x-ray results, treatment options and other information from previous visits at Align Chiropractic.

- I understand that signing this form is voluntary and that information may be released to family members or others without this form, if allowed by federal and state law.\*
- I understand that listing a person on this form does not give them the right to receive or copy my written medical records. It does not allow them to consent for health care services on my behalf. \*\*
- I understand this form is not used to share information about patients who are minors. \*\*

Name	Phone Number	Name	Phone Number

I understand this form will remain relevant until otherwise stipulated by myself. I can update this form at any time by completing a new form and turning it into my provider. I can revoke or cancel this form at any time by giving my provider written notification.

Print Name: \_\_\_\_\_

DOB: \_\_\_\_\_

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

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