



# PATIENT REGISTRATION

DATE: \_\_\_\_\_

LEGAL NAME: \_\_\_\_\_ Male  Female

First Middle Last

Title: \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_

SSN#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ APT#: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ Position: \_\_\_\_\_

Occupation: \_\_\_\_\_ Full/Part Time: \_\_\_\_\_ Retired?: Yes  No

Business Address: \_\_\_\_\_

SPOUSE/PARTNER NAME: \_\_\_\_\_ Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_ Business Phone: \_\_\_\_\_

EMERGENCY CONTACT (other than spouse): \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

PERSON RESPONSIBLE FOR ACCOUNT (If other than patient): \_\_\_\_\_

Relationship: \_\_\_\_\_ SSN: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

PRIMARY INSURANCE COMPANY: \_\_\_\_\_

Group#: \_\_\_\_\_ Policy or Claim#: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Subscriber's SSN#: \_\_\_\_\_

Subscriber's Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

IF INJURED: Date: \_\_\_\_\_  Injured at Work? Cause: \_\_\_\_\_

REFERRED TO THIS OFFICE BY: \_\_\_\_\_

**FINANCIAL POLICY**

**PAYMENT:**

1. Payment for all visits, supplements, and labs is expected at the time of service, unless some other pre-approved payment arrangement is made with the office.
2. Cash, check and Mastercard/Visa/Discover are accepted forms of payment
3. If a payment cannot be made on the day of service, post-dated checks are acceptable.

**INSURANCE:**

4. Some insurance policies offer full or partial coverage for Chiropractic or Naturopathic care. Our billing department will submit the appropriate billing forms, if Dr. Dumovic is a provider for your insurance company. However it is your responsibility as the patient to verify with your insurance carrier if your particular plan has coverage for the care you are receiving.
5. Some insurance plans require a referral from your PCP (Primary Care Physician) in order for the treatment to be covered by your insurance company. It is your responsibility to know if your insurance plan requires one, and to obtain it from you PCP prior to your appointment with this office. In the event that no referral is in place, you are still responsible for any non-covered expenses.

**ON-THE-JOB INJURIES:**

6. Workman's Compensation does provide for Chiropractic & Naturopathic care. On-the-job injuries are billed by the office to the State and private L&I agencies. Payment for denied claims is the responsibility of the patient.

**PERSONAL INJURIES/AUTO ACCIDENTS:**

7. Auto accidents or personal injury cases are billed by this clinic with verification of your insurance company or attorney. It the patient's responsibility to obtain policy and claim numbers for the Personal Injury Protection (PIP), insurance coverage, the adjuster's name, and the billing address. It is also the patient's responsibility to obtain an attorney to help in the settlement of all medical fees, emotional trauma, attorney fees, and any time loss incurred.

**GENERAL POLICY FOR ALL OF THE ABOVE:**

8. There is a \$36.00 charge for all returned checks.
9. We request a minimum of 24 hours notice for appointment changes and cancellations. Not giving adequate notice of cancellation or missing an appointment will result in a minimum \$35.00 charge. We reserve the right to charge up to the full amount of the missed appointment. Please note: If you are 15 minutes late for a chiropractic appointment or 30 minutes late for a Naturopathic appointment you have missed your appointment and will need to reschedule.



I have read and understand this Financial Policy. I hereby authorize Dr. Dumovic to perform diagnostic tests deemed necessary for my care, and to perform any and all forms of treatment, medication, and therapy that are indicated, and that I am in agreement with, which are in accordance with the Standards of Naturopathic/Chiropractic medicine. I hereby authorize the doctor to release any information required by my insurance company to expedite payment of claims submitted. I also authorize my insurance benefits to be paid directly to Dr. Dumovic, and understand that I am financially responsible for any services not covered by my insurance carrier. I agree to pay any outstanding balance in a timely manner.

**PRINT NAME:** \_\_\_\_\_ **SIGNATURE:** \_\_\_\_\_

**WITNESSED BY:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

# Informed Consent for Treatment

I hereby request and consent to the performance of naturopathic and/or chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic and naturopathic named below and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic/naturopathic treatments. Those complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homer's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, that are in my best interest.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of treatment. I state that I have been informed and weighed the risks involved in naturopathic and chiropractic treatment at this health care office. I have decided that it is in my best interest to receive treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

**SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE**

\_\_\_\_\_  
Printed name of Patient

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Guardian/Parent

\_\_\_\_\_  
Date

(If patient is under 18 years old, or is physically or mentally unable to sign – this signature indicates guardian consent for the Doctor to treat the patient.)

\_\_\_\_\_  
Witness to Patients Signature

\_\_\_\_\_  
Date

# STATEMENT OF PRIVACY PRACTICES

Joseph L. Dumovic D.C., N.D.  
P.O. Box 177  
Hobart, WA 98025

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

## Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given to anyone – even family members – without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

## Collecting Protected Health Information

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

## Disclosure of your Protected Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards.

## Patient Rights

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

Dumovic Clinic

initials \_\_\_\_\_

## ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Dr. Joseph L. Dumovic. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and the duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Dr. Joseph L. Dumovic reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that it be mailed to me.

### ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

Any member of my immediate family	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse only	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other (please specify)	<input type="checkbox"/> Yes <input type="checkbox"/> No

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Signature (of Patient or Personal Representative)

\_\_\_\_\_  
Description of Personal Representative's Authority

\_\_\_\_\_  
Date

### OFFICE USE ONLY BELOW THIS POINT

#### RECORD OF ACKNOWLEDGEMENT

Provided Prior to Treatment?  Yes  No

Date Provided:

If not provided, reason for denial:

- Needed more time to review statement of privacy practices.
- Wanted to consult with another person before signing.
- Unable to sign.
- Reason not given.
- Other (explain):

# CHIROPRACTIC INTAKE

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

Main Symptoms: \_\_\_\_\_  
\_\_\_\_\_

Did the symptoms start:

- ◆ suddenly?
- ◆ gradually? \_\_\_\_\_

Type of pain (sharp, dull, aching, intermittent, any radiating pain or numbness, etc): \_\_\_\_\_  
\_\_\_\_\_

What have you been doing for it? \_\_\_\_\_

What type of treatment have you had for this condition? \_\_\_\_\_

Is there anything that:

- ◆ relieves the pain?
- ◆ aggravates the pain? \_\_\_\_\_

Have you ever injured this area before? If so, describe the injury: \_\_\_\_\_  
\_\_\_\_\_

Any x-rays taken? \_\_\_\_\_

Other symptoms: \_\_\_\_\_  
\_\_\_\_\_

Are you taking any medications, including over-the-counter medications? If so, please list them below: \_\_\_\_\_  
\_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Childhood illnesses: \_\_\_\_\_

Accidents: \_\_\_\_\_

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

Surgeries/hospitalizations: \_\_\_\_\_  
\_\_\_\_\_

Stress factors currently in your life? \_\_\_\_\_  
\_\_\_\_\_

Jpdated 5/10

Date of Visit: \_\_\_/\_\_\_/\_\_\_ Patient: \_\_\_\_\_ Age: \_\_\_\_\_

What brought you here today? \_\_\_\_\_

Place an "X" on the drawing below on areas causing you pain and a letter describing it

A = ACHE  
 B = BURNING  
 S = STABBING  
 N = NUMBNESS  
 P = PINS & NEEDLES

**PAIN SCALE**

Please circle the number that best describes your pain

0 1 2 3 4 5 6 7 8 9 10

NONE LITTLE MEDIUM SEVERE

Describe your past health history:

Prior Illness: \_\_\_\_\_

Past Hospitalizations: \_\_\_\_\_

Surgeries: \_\_\_\_\_

Medications: \_\_\_\_\_

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

(DO NOT WRITE BELOW THIS LINE)

**INITIAL EVALUATION & MANAGEMENT**

**Range of Motion**

Cervical	Normal	Pain
Flexion	50	
Extension	60	
Left Lat Flex	45	
Right Lat Flex	45	
Left Rotation	80	
Right Rotation	80	
Lumbar	Normal	Pain
Flexion	60	
Extension	25	
Left Lat Flex	25	
Right Lat Flex	25	
Left Rotation	30	
Right Rotation	30	

Health HX Notes:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Asymmetry**

Using arrows (↑ ↓ → ←) mark the misaligned vertebrae

C0  
C1  
C2  
C3  
C4  
C5  
C6  
C7

L1  
L2  
L3  
L4  
L5  
SAC  
L-IL  
R-IL

T1  
T2  
T3  
T4  
T5  
T6  
T7  
T8  
T9  
T10  
T11  
T12

Using arrows (↑ ↓), mark postural asymmetry

**Tissue**

Mark tissue abnormalities  
 TP, LG, TN, SK, FS

TP=Trigger Points; LG=Ligaments (swollen or tender)  
 TN=Tendons; SK=Skin; FS=Fascial Restrictions