VERG CHIROPRACTIC AND MANUAL THERAPY
109 SE 101st Ave, Vancouver, WA 98664
Office Phone: (360) 553-1050. Fax: (360) 828-7301

Confidential Patient Information

Patient Information

Name_____
Address_____
_____
City State Zip Code

Home Phone _____
Cell _____

Birthdate _____ Age _____ Sex: ☐M ☐ F

□Married □Single □Widowed □Separated □Divorced

Occupation _____
Employer _____
Work Phone _____

Accident Information

Is the condition due to an Accident? □Yes □No
Date of Accident _____
Type of Accident, □Auto □Work □Home □Other
What state did the Accident occur in? _____
To whom have you reported the Accident?
□Auto Insur. □Employer □Worker's Comp □Other
Attorney Name (if applicable)_____
Attorney phone number_____

Insurance Information

Your Insurance Company _____
Phone Number _____
Claim # _____
Group # _____
Do you have PIP? (personal injury protection): Yes ☐ No☐

Emergency Contact

In case of an emergency, whom may we contact?
Name _____Phone _____
Relationship _____Work phone _____

To better inform your medical doctor of the status of your health, we would like to personally report your condition to them. Please provide their contact information.

Doctor's Name _____ MD/DC/DO
Clinic/Group _____
Address _____
City, Stat, Zip _____
Phone _____

Do you have:

High Blood Pressure □Yes □No
Pacemaker □Yes □No
Cardiac or Circulatory Problems □Yes □No
Infectious Disease □Yes □No
Do you bruise easily □Yes □No
Are you Pregnant? □Yes □No
Due Date _____

Consent to Treat

I hereby authorize doctor(s) or other providers of this clinic and whomever they may designate as their assistants to administer treatment as they so deem necessary.

Chiropractic examination and therapeutic procedures (including spinal adjustment, ultrasound therapy, heat application, electrotherapy, and manual muscle therapy) are considered safe and effective methods of care. However, any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications include, but are not limited to: soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare. Claims have been made that Chiropractic treatment could cause a stroke but recent research has shown that the likelihood of such event is not greater than a stroke after a visit to a Primary Care Provider (JMPT. 2009;32(2): S201-S208). Other research concluded that such association is due to chance. Additional information on side effects is available upon request. **I have read and understand the above statements regarding treatment side effects. I also understand that there is no guarantee or warranty for a specific cure or result.**

Signature of Patient or (Patient's Guardian):

_____ Date_____

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CLINIC ACCOUNT POLICY

- Payment is expected at the time of service.
- As a service to you, we will bill your insurance company. If we can document your coverage, we will ask you to pay your co-pay, percentage, deductible or non-covered service fee at the time of each visit.
- Information received from the insurance company **IS NOT A GUARANTEE OF BENEFITS.** You are responsible for all charges incurred in this office.
- If you have had a personal injury (automobile accident), we will bill your personal injury protection carrier (your auto insurance).
- Patients paying cash at the time of service may receive cash discount.
- If at any time you would like a copy of your fee schedule, please do not hesitate to ask.
- If you need assistance or need to make special arrangements, please talk to the Dr. Vergulyanets.

PATIENT AGREEMENT - ASSIGNMENT AND RELEASE

- I authorize the release of any information including diagnosis and the records of any treatment rendered to me or my child during the period of such care to third party payers and/or other health practitioners.
- I authorize and request my insurance company to pay directly to Dr. Anatoliy Vergulyanets all medical benefits otherwise payable for services. **I understand that I am financially responsible for all charges whether or not paid by insurance, and I have read and understand the financial policy of this office.** I authorize the use of this signature on all my insurance submissions and to obtain other medical records and radiographic/CT/MRI images and there corresponding reports.

PRIVACY POLICY

- We are required by federal and state law to maintain the privacy of your health information. We are also required to give you a policy outlining our privacy practices.
- **I have been offered a copy of this office's HIPPA Privacy Policy and I understand its content.**

I have read and understand the above account policy, Patient Agreement, and Privacy Policy.

Patient Name: _____ Date of Birth: _____

Signature of Patient (or Patient's Guardian): _____ Date: _____