Bourree Chiropractic and Massage
12841 NE 85th Street
Kirkland, WA 98033

Health Information

A) Patient Information

Patient Name: ______________________ M/F (circle) SS#_____________________ Date of Birth: ____________________
Today's Date: __________
Address: ____ City: ___________________ State: ______Zip_____________
Phone: Home _______________________ Cell _____________________________ Work ___________________________
Email: ____
I authorize Bourree Chiropractic and Massage to leave health related information at the above (Circle): HOME/CELL/WORK, Phones/Answering machines/Voice mail
Employer: ________________________________ Occupation: ______________________ Date of Injury: _________________
Preferred Language: __________ Ethnicity Select One: ☐Hispanic. ☐Non-Hispanic ☐Unknown (A person who cannot or refuses to declare ethnicity)
Race Select One: ☐White ☐Black ☐Native American/Eskimo/Aleut ☐Asian/Pacific Islander ☐Other ☐Unknown
How Did You Hear About Us____

Emergency Contact
Name: __________________________ Home Phone: ________________________ Cell Phone: _________________________
Email: ____________________
Primary Health Care Provider
Name: __________________________ Address: ____________________City: _______________State: ________ Zip: ______
Phone: __________________________ Fax: _______________________________ Email: ____________________________

B) Current Health Information

List Health/Concerns. Check all that apply.
Primary____
☐Mild ☐Moderate ☐Disabling ☐Constant ☐Intermittent
☐Symptoms ↑w/activity ☐Symptoms ↓w/activity ☐Getting Worse ☐Getting Better ☐ No Change
Treatment Received____________________________________ Additional ____
Have you ever received Manual/Massage Therapy or Laser Treatment before? ☐YES ☐NO Frequency: _________________
List the all medications (including over the counter pain relievers and herbal remedies): _____________________________
____
List all medications taken in the last 3 months:____
List all allergies (include environmental and food): ____
Do you Smoke? ☐YES ☐NO, E-Cigs? ☐YES ☐NO, Marijuana? ☐YES ☐NO, Chewing Tobacco? ☐YES ☐NO
If yes, how long have you smoked? ____________ How many packs per day/week? __________Have you been offered smoking cession materials? ☐YES ☐NO
If you have not been offered smoking cession materials would you like that information provided at your next visit? ☐YES ☐NO

C) Health History

List and explain. Include dates and treatment received.
Surgeries: ____
Accidents: ____
Major Illness: ____
Date of last physical/annual exam:___________ Date of last Blood Tests: ____________ Date of last X-Rays: ______________

Phone: 425-827-0334 Fax: 425-284-6884

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D) Family Medical History

Father: Alive? ☐YES ☐NO Current Age: ____Deceased? ☐YES ☐NO Age of Death: ____ Cause of Death: ____________

My Father's general health is:

☐ Excellent ☐ Good ☐Fair ☐Poor

Check those to which the answer is yes (leave others blank)

☐ Heart attacks ☐Strokes ☐High blood pressure ☐Elevated Cholesterol ☐Diabetes ☐ Asthma or Hay Fever

☐ Congenital Heart Disease ☐Glaucoma ☐Leukemia ☐Obesity ☐Cancer

Mother: Alive? ☐YES ☐NO Current Age: ____Deceased? ☐YES ☐NO Age of Death: ____ Cause of Death: ____________

My Mother's general health is:

☐ Excellent ☐ Good ☐Fair ☐Poor

Check those to which the answer is yes (leave others blank)

☐ Heart attacks ☐Strokes ☐High blood pressure ☐Elevated Cholesterol ☐Diabetes ☐ Asthma or Hay Fever

☐ Congenital Heart Disease ☐Glaucoma ☐Leukemia ☐Obesity ☐Cancer

Siblings: Number of brothers:___________ Number of sisters:___________ Age Range:_____________

Health
Problems:____
____

Additional Family Health Problems or
Comments:____

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Please check All Current and Previous Conditions:

General

Current	Past	Comments	Current	Past	Comments
☐	☐	Headaches _____________	☐	☐	Pain _________________
☐	☐	Fatigue ________________	☐	☐	Infections _____________
☐	☐	Sinus _________________	☐	☐	Fever ________________
☐	☐	Sleep Disturbances _____	☐	☐	Other ________________

Skin Conditions

Current	Past	Comments	Current	Past	Comments
☐	☐	Rashes _______________	☐	☐	Warts ________________
☐	☐	Athlete's Foot ________	☐	☐	Other ________________

Muscles and Joints

Current	Past	Comments	Current	Past	Comments
☐	☐	Rheumatoid Arthritis	☐	☐	Osteoarthritis
☐	☐	Broken Bones	☐	☐	Spinal Problems
☐	☐	Lupus	☐	☐	TMJ, Jaw Pain
☐	☐	Sprains/Strains	☐	☐	Tendonitis, Bursitis
☐	☐	Weak/Sore Muscles	☐	☐	Neck/Shoulder/Arm Pain
☐	☐	Scoliosis	☐	☐	Disk Problems
☐	☐	Spasms/Cramps	☐	☐	Stiff/Painful Joints
☐	☐	Low Back/Hip/Leg Pain	☐	☐	Other_________________

Nervous System

Current	Past	Comments	Current	Past	Current
☐	☐	Head Injury/Concussion	☐	☐	Numbness/Tingling
☐	☐	Depression	☐	☐	Dizziness/Ear Ringing
☐	☐	Sciatica/Shooting Pain	☐	☐	Loss of Memory/Confusion
☐	☐	Chronic Pain	☐	☐	Other__________________

Respiratory, Cardiovascular

Current	Past	Comments	Current	Past	Current
☐	☐	Heart Disease	☐	☐	Lymphedema
☐	☐	Poor Circulation	☐	☐	Chest pain
☐	☐	Shortness of Breath	☐	☐	Blood Clots
☐	☐	High/Low Blood Pressure	☐	☐	Swollen Ankles
☐	☐	Asthma	☐	☐	Stroke
☐	☐	Irregular Heartbeat	☐	☐	Varicose Veins

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Digestive/Elimination System

Current	Past	Comments	Current	Past	Current
☐	☐	Bowl Dysfunction	☐	☐	Abdominal Pain
☐	☐	Gas/Bloating	☐	☐	Bladder Dysfunction
☐	☐	Kidney Dysfunction	☐	☐	Other_________________

Endocrine System

Current	Past	Comments	Current	Past	Current
☐	☐	Thyroid Dysfunction	☐	☐	Diabetes

Reproductive System

Current	Past	Comments	Current	Past	Current
☐	☐	Pregnancy	☐	☐	Painful/Emotional Menses
☐	☐	Fibrotic Cysts	☐	☐	Other

Cancer/Tumors

Current	Past	Comments	Current	Past	Current
☐	☐	Benign	☐	☐	Malignant

Contract for Care

I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by my manual therapist and other members of my health care team, and my experiences of those suggestions. I agree to participate in the self-care program we select. I promise to inform my practitioner any time I feel my well-being is threatened or compromised. I expect my manual therapist or other health care professional to provide safe and effective treatment.

Consent for Care

It is my choice to receive care, and I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health.

Signature: ____ Date: ___________________________________

Signature of Parent or Guardian: ______________________ Date: ___________________________________

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Release of Records

Date: ___________________

To: ____
____
____
____

I, ____, hereby request the above-named to release copies of all pertinent medical records and records and x-ray films to Bourree Chiropractic and Massage, David Bourree, DC, DACS as of the above date. These records may be sent directly to the doctor/clinic, or given to me personally.

Signed:____
(Patient and/or Patient's Representative)

Date of Signature: ____

Records to be sent to: David Bourree, DC, DACS
12841 NE 85th Street
Kirkland, Washington 98033
ATTN: Dr. David Bourree

Original records and x-ray films will be returned when they have served their purpose.
Thank you for your cooperation.

Phone: 425-827-0334 Fax: 425-284-6884

Bourree Chiropractic and Massage
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Assignment of Insurance Benefits

I authorize Bourree Chiropractic and Massage to bill: ____________________________
Insurance company, and to pay by check made out directly to:

Bourree Services, P.S

This is a direct assignment of my benefits and rights under this policy. This payment will not exceed my indebtedness to the assignee and I have agreed to concurrently pay any balance of said services which may exceed this insurance payment.

Signature of policy holder

Signature of claimant, if not policy holder

There is a possibility that insurance may not cover your services in this office. This may be because your insurance may deem the service not medically necessary, or may not be covered under your insurance plan, or the appropriate referral may not be in place.

The carrier authorizes the provider to charge the patient for the services so long as this disclosure is made and signed by the patient prior to the services being provided.

The undersigned patient acknowledges that the non-covered status of the proposed services has been explained, and that the patient's care may not be covered by or has not been authorized by the patient's insurance plan. The undersigned acknowledges that if any portion of the care provided is not, or may not be covered by insurance, then the undersigned shall be responsible for payment, and shall make the necessary financial arrangements with the healthcare provider to pay these services. I understand that Bourree Chiropractic and Massage may charge a 1% interest on outstanding balances.

Print Name: _________________________________Signature:_______________________________

Date: _______________________________________Insurance Plan: ___________________________

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Authorization for Taking and Retaining X-Ray Films

Date: ____________________

I hereby authorize the taking of analytical x-ray films by the above doctor/clinic, and/or staff of such areas as may be of anatomical interest and which may be recommended from time to time by the above doctor or doctors.

Further, I agree that the above doctor/clinic shall be the sole owner of such analytical films and shall remain in custody and in control of said films, until such a time as I shall sign a Release Form stating otherwise: such form to be provided by the above upon request.

Print Name: _____________________________ Signature: ____

Parent or Guardian (if applicable): ____

Witness Name: __________________________ Witness Signature: __________________________________

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

Date of last menstrual cycle: __________________________________

Signature: _____________________________________ Date: ______________________________________

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Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by **Bourree Chiropractic and Massage** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Bourree Chiropractic and Massage.**

I understand that diagnosis or treatment of me by **Dr. David Bourree** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. **Bourree Chiropractic and Massage** is not required to agree to the restrictions that I may request. However, if **Bourree Chiropractic and Massage** agrees to a restriction that I request, the restriction is binding on **Bourree Chiropractic and Massage** and **Dr. David Bourree.**

I have the right to revoke this consent in writing at any time, except to the extent that **Dr. David Bourree** or **Bourree Chiropractic and Massage** has taken action in reliance on this consent.

My "protected health information" means health information including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to **review Bourree Chiropractic and Massage's** Notice of Privacy Practices prior to signing this document.

Bourree Chiropractic and Massage's Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of **Bourree Chiropractic and Massage.**

The Notice of Privacy Practices for Dr. David Bourree is also provided at the front desk of **Bourree Chiropractic and Massage.**

This Notice of Privacy Practices also describes my rights and the duties of **Dr. David Bourree** with respect to my protected health information.

Bourree Chiropractic and Massage reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

____
Date

Description or Personal Representative's Authority

With whom may we discuss your healthcare and appointments? ____

How may we leave message for you (phone number for voicemail)? ____

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MISSED APPOINTMENT POLICY

Dear Patients,

All appointments are scheduled time with you and the doctor; therefore when an appointment is missed, someone else could have had that scheduled time with the doctor.
Twenty-Four Hour advanced notice is required for an appointment cancellation.
If this notice is not given, a missed appointment fee of $45.00 will be charged directly to you. It is important to know that insurance companies do not pay for this, and it must be paid before your next visit to this office.

Please keep your appointments.

Yours for better health,

Dr. Bourree & Staff

I have read and agreed to the above information provided.

NAME: ______________________________ Date: _________________________

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment. Below are definitions that will help you better understand the care you will receive in our office.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

HEALTH: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a specialist in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, ____________________________, have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

______________________________________ ______________________________________
(Signature) (Date)

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Insurance Non-Covered Service Disclosure & Agreement

Name of Patient: ____________________________

Name of Provider: David Bourree D.C. DACS

Type of Service:

1. **Exams:** 99201-99205: $60.00--$285.00
2. **X-Rays:** 72010-722200: $25.00--$260.00
3. **Re-Exams/Report of Findings:** 99211-99215: $40.00--$195.00
4. **Adjustments:** 98940-98942: $50.00--$78.00
5. **Extremity Adjustments:** 98943: $35.00
6. **Intersegmental Traction, Ice:** 97012, 97010: $15.00--$45.00
7. **Chiropractic Supplies, i.e., pillows, inserts, ice packs, etc.:** $3.50--$90.00
8. **Exercises and Rehabilitation:** 97110, 97150, 97112, 97530: $15.00--$55.00
9. **Massage Therapy:** 970124: $150.00
10. **Laser Therapy:** S8948: $75.00

Proposed Dates or Range of Dates of Services: See Chiropractic or Rehabilitation Care Schedule

Potential Reasons for Non-covered Status:

- The service is or may be deemed investigational or experimental under the carrier's internal guidelines.
- The service is considered, or may be deemed, not medically necessary under the carrier's internal care or cost management guidelines.
- The service is not or may not be actually covered under the plan to which the above patient is subscribed.
- The service is not or may be deemed as not provided in accordance with the Provider's Agreement with the carrier or other requirements of the carrier's or managed care entity's internal guidelines.

The carrier authorizes the provider to charge the patient for the above services so long as this disclosure is made and signed by the patient prior to the services being provided.

Patient Financial Responsibility:
The undersigned patient acknowledges that the Non-Covered status of the proposed service(s) has been explained, and that a certain portion of the patient's care may not be covered by or has not been authorized by the patient's insurance plan. The undersigned acknowledges that if any portion of the care provided is not, or may not be, covered by insurance, then the undersigned shall be responsible for payment, and shall make the necessary financial arrangements with the healthcare provider to pay for these services. We reserve the right to charge 1% on outstanding balances, per Washington State Allowable Laws.

Print Name: ____ Signature: ____

Date: ____ Insurance Plan: ____

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