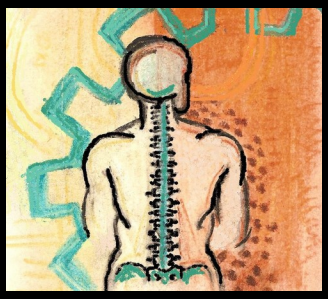

Olsen Chiropractic LLC dba

Just For The Health Of It

Getting Healthy Is Fun!

2402 Broadway St Vancouver WA 98663
319 Kuualoha St Kahului HI 96732
53 Emmons Rd Grand Lodge Suite 174 Crested Butte CO 81225

Tel: (360) 241-6630
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Patient Information Sheet (Please Complete both Sides):

Name: _____Age: _____DOB:____/____/_____

Marital Status: ☐Married / ☐Partner / ☐Single / ☐Divorced / ☐Separated / ☐Widow

Address: _____

City: _____ State: _____ Zip: _____

Home Phone:(____)_____Cell Phone:(____)_____ Work Number:(____)_____

Email:_____

Employer: _____Occupation:_____

Brief Work Activity Description:

_____

_____

Nearest Relative: _____Relation to you:_____Phone Number: (____)_____

Emergency Contact: _____Phone Number: (____)_____

Referred By? ☐Website ☐Insurance List ☐Current patient: ☐Event: ☐Other:

Reason For this Visit? ☐Illness / ☐Injury / ☐Job related injury /☐Auto Accident / ☐Check-up/ ☐Other
How do you intend to pay? Cash / Credit Card / Insurance / Medicare / Workers Compensation/ Auto **Accident / Other:**

(Filled Out by Office Manager, *Please give insurance card to front desk*):

Company: _____ Phone Number: (____)_____
Address:_____
Patient ID:_____Group Number:_____
Coverage:ND,LAC,LMT: _____
Xrays:_____Orthotic:_____Cervical Pillow:_____
Deductable:_____Copay:_____
Referral Needed: Notes:

Please Read and Sign:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Just For the Health of It will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Just For the Health of It will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. If it becomes necessary to effect collections of any amount owed on this or subsequent visits the undersigned agrees to pay for all costs and expenses including reasonable attorney fees. I hear by authorize the doctor to release information necessary to secure payment of benefits

Signature:_____ **DATE**:____/____/_____

Patient Name:_____ **DOB**:____/____/_____

Please Fill Other Side……..>

Injury Information

What are your injuries or complaints?_____
_____
_____
Who have you seen for them so far?_____
When did they start?_____
What activities aggravate your condition?_____
_____
_____
Have you seen a chiropractor before? ☐No ☐Yes Year(s)_____
List Sport and Hobby Description and repeated Daily activities:_____
List all Forms of exercise:_____
_____
How many glasses of water do you drink a day?_____
List Medications/Supplements:_____
Previous Car Accidents? ☐No ☐Yes, Year(s)_____
_____
Serious Illnesses/Hospitalizations/Surgeries? ☐No ☐Yes _____

Please check the appropriate boxes:

☐ ☐ Dizziness	☐ ☐ Sciatica	☐ ☐ Tuberculosis	☐ ☐ Difficulty Breathing
☐ ☐ Headache	☐ ☐ Spinal Curvatures	☐ ☐ Bruise Easily	☐ ☐ Pleurisy
☐ ☐ Allergies	☐ ☐ Swollen Joints	☐ ☐ Hay fever	☐ ☐ Cancer
☐ ☐ Depression	☐ ☐ Colon Trouble	☐ ☐ Nosebleeds	☐ ☐ Itching
☐ ☐ Knee Pain	☐ ☐ Difficult Digestion	☐ ☐ Sinus Infections	☐ ☐ Varicose Veins
☐ ☐Ankle Pain	☐ ☐ Hemorrhoids	☐ ☐ High blood pressure	☐ ☐ Bed-Wetting
☐ ☐ Hip Pain	☐ ☐ Asthma	☐ ☐ Low blood pressure	☐ ☐ Frequent Urination
☐ ☐ Numbness	☐ ☐ Deafness	☐ ☐ Pain Over Heart	☐ ☐ Kidney Infections
☐ ☐ Tingling	☐ ☐ Ear Noises	☐ ☐ Poor Circulation	☐ ☐ Prostate Trouble
☐ ☐ TMJ Pain	☐ ☐ Enlarged Thyroid	☐ ☐ Rapid Heart Beat	☐ ☐ Cramps/Backache
☐ ☐ Anemia	☐ ☐ Stroke	☐ ☐ Chest Pain	☐ ☐ Excessive Menses
☐ ☐ Alcoholism	☐ ☐ Diabetes	☐ ☐ Polio	☐ ☐ Hot Flashes
☐ ☐ Fatigue	☐ ☐ Ulcers	☐ ☐ Bursitis	☐ ☐ Rashes/Skin Lesions

List Typical Breakfast Foods:_____
List Typical Lunch Foods:_____
List Typical Dinner Foods:_____
List Typical Snacks and Beverages_____
List Hours of Sleep_____Tobacco Use:_____Cups/Coffee:_____
List all types of exercise_____Alcohol:_____Drugs:_____

Consent to Treatment

I the undersigned being 18 years of age or older, give my consent to examination and treatment as deemed necessary and acceptable, understand that there are risks involved in the treatment of the spine and associated structures.

Patient Signature:_____Date:_____

I, the undersigned parent/or person having legal custody/guardianship of the above named minor, do hereby authorize and consent to any x-ray, examination and chiropractic diagnosis or treatment, which is deemed advisable by a licensed chiropractor of this office. This authorization shall remain in effect until revoked by the undersigned parent/guardian.

Parent/Guardian Signature:_____Date:_____

FINANCIAL POLICY

It is the policy of Olsen Chiropractic LLC dba Just For The Health Of It ("Olsen Chiropractic") that, all care and services rendered are charged directly to you, the patient, and you are ultimately responsible for all payments, regardless of whether or not this office accepts insurance assignment. Olsen Chiropractic will handle the billing details with the insurance company(s) on your behalf. Olsen Chiropractic will not accept assignments with any insurance company. However, Olsen Chiropractic, at the sole discretion of Dr. Cara Olsen, may wait for payment until your particular case is settled provided that you obtain an attorney who is willing to protect the fees and charges from Olsen Chiropractic. Furthermore, the attorney must be willing, and signs a document stating he/she will protect the fees, and charges of Olsen Chiropractic. Olsen Chiropractic may file a medical lien as part of our billing and collection process. All payments are expected at the time of service or at the end of each week. Patient balances may not exceed $200.00 at any time, or professional services may be terminated. A financial charge of one percent (twelve percent annually)-minimum $2.00 charge and subject to change-will be assessed for my account when in excess of the amount stated above. The financial change will be assessed at or near the time of the billing cycle at the end of each month. This office will bill your insurance company for you on a regular basis. I understand that my insurance policy is a contract between the insurance company and myself. Therefore, I am ultimately responsible for payment of all care and services rendered to me by Olsen Chiropractic. A non sufficient funds charge (NSF), of no less than $20.00 and subject to change will be charged for each check or credit card transaction returned as NSF. I also acknowledge and understand that if I suspend or terminate my care and treatment, any fees and charges for professional services rendered for me will be immediately due and payable. In the event of a delinquency and or a dispute of my account and/or if my case is turned over to collections for non-payment, I am responsible for all collection and legal fees accrued as a result of the action(s).

My signature below verifies that I have been informed of the financial policy of Olsen Chiropractic DBA Just For The Health Of It, that I fully understand, and I am in agreement with the financial policy of Olsen Chiropractic.

Patient Signature:_____

Print Patient Name:_____

Date:_____

COMMUNICATION CONSENT FORM

Consent to Email, Voicemail, Phone-call and or Text Message for Appointment Reminders and other Healthcare Communications: Patients in our practice may be contacted via phone, email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

I consent to receiving appointment reminders and other healthcare communications/information via phone, email and/or text from Just For the Health of it Clinic or its designated vendor.

_____(Patient Initials) I consent to receive voicemail, email, and/or text messages from the practice or designated vendor at my cell phone and any number forwarded or transferred to that number.

The cell phone number that I authorize to receive voicemail and/or text messages for appointment reminders, feedback, and general healthcare reminders/information is:

Phone:	Carrier:

_____(Patient Initials) I consent to emails, to receive communications as stated above.

The email that I authorize to email messages for appointment reminders and general health reminders/feedback/information is:

Email:

*I understand that this request to receive emails, voicemail and/or text messages will apply to all future appointment reminders, feedback, and general health information.

_____(Patient Initials) I hereby revoke my request to receive any future appointment reminders, feedback, and general health information via the communications methods mentioned above.

_____(Patient Initials) I do NOT consent to any of the forms of contact stated above. *I have reviewed and acknowledge the Just For the Health of it Clinics No-Show notice/policy.

X	X
Signature (First and Last Name)	**Date**