

Health Questionnaire
M^cCracken Chiropractic & Wellness Center
284 Central Way
Kirkland, WA 98033

Upper / Lower Extremities

		Same as above	Pain	Numbness	Tingling	Stiffness	Soreness	Swelling	Weakness											
L E F T	Shoulder																			
	Arm	<input type="checkbox"/>																		
	Elbow	<input type="checkbox"/>																		
	Forearm	<input type="checkbox"/>																		
	Wrist	<input type="checkbox"/>																		
	Hnds/Fingrs	<input type="checkbox"/>																		
R I G H T	Shoulder																			
	Arm	<input type="checkbox"/>																		
	Elbow	<input type="checkbox"/>																		
	Forearm	<input type="checkbox"/>																		
	Wrist	<input type="checkbox"/>																		
	Hnds/Fingrs	<input type="checkbox"/>																		
L E F T	Hip																			
	Buttock	<input type="checkbox"/>																		
	Thigh	<input type="checkbox"/>																		
	Knee	<input type="checkbox"/>																		
	Leg/Calf	<input type="checkbox"/>																		
	Ankle	<input type="checkbox"/>																		
	Foot	<input type="checkbox"/>																		
R I G H T	Hip																			
	Buttock	<input type="checkbox"/>																		
	Thigh	<input type="checkbox"/>																		
	Knee	<input type="checkbox"/>																		
	Leg/Calf	<input type="checkbox"/>																		
	Ankle	<input type="checkbox"/>																		
	Foot	<input type="checkbox"/>																		

When did your **upper** extremity complaint begin?
 Date: ___/___/____

When did your **lower** extremity complaint begin?
 Date: ___/___/____

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B. PATIENT'S COMPLAINTS (CONTINUED)

2. How Did Your Complaints Begin?

- Unknown Suddenly Gradually

3. What Happened To Cause Or Re-Aggravate Your Complaint(s)?

- Unknown Work Accident/Injury Personal Injury
 Auto Accident Home Accident Sports Injury
 Other – Describe: _____
-
-

4. How Would You Rate Your Pain Today Where 0 Is No Pain And 10 Is The Worst Pain?

- No 0 1 2 3 4 5 6 7 8 9 10 Worst Pain
Pain Possible

5. When Are Your Symptoms Worse?

- Morning Afternoon Evening Night
 Always the Same

6. What Makes Your Condition Better?

- Nothing Stretching Heat Rest
 Sitting Exercise Ice Standing
 Medications Other: _____

7. What Makes Your Condition Worse?

- Nothing Coughing Reaching Standing
 Sneezing Lifting Sitting Pulling
 Bending Walking Straining Turning
 Other: _____

8. Have Any Of Your Complaint(s) Existed In The Past? Yes No

If Yes, Indicate below

- Neck Upr Back Mid Back Low Back Ribs
 Shoulder Arm Elbow Forearm Wrist
 Hnd/Fngrs Buttock Hip Thigh Knee Leg/Calf
 Ankle Foot Others: _____

9. Have You Had Any Recent Treatment For Your Conditions OUTSIDE Of This Office? Yes No If Yes, List Dates, Treatments And Doctors.

10. Since Your Symptoms Began, Have You Noticed A Change In?

- Bowel Function
 Bladder Function No To All
 Sexual Function

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C. HEADACHES

If You Are Experiencing Headaches, Please Fill Out This Section Otherwise Skip To Section D.

- 1. Where Is The Pain Associated With Your Headaches Located?**
 Left Side Of Head Right Side Of Head Base Of Skull Left Jaw Joint
 Right Jaw Joint Over Eyes Behind Eyes Over Sinuses
- 2. On What Date Did Your Headaches Begin?**
Date: ___/___/____ Same As Neck/Back Complaints
- 3. How Does The Intensity Of Your Headaches Rate?**
No 0 1 2 3 4 5 6 7 8 9 10 Worst Pain
Pain Possible
- 4. What Describes Your Pain?**
 Dull Sharp Aching Stabbing Deep Vice-like Burning
 Throbbing/Pulsating Other: _____
- 5. When Do Your Headaches Usually Start?**
 Constant Midday Wake Up With In Morning Evening
- 6. What Seems To Bring On Your Headaches?**
 Physical Activity Excessive Stress Caffeine Certain Foods
 Alcohol Menstrual Period Other: _____
- 7. How Often Do They Occur?**
 Daily Weekly Monthly Other: _____
- 8. How Long Do Your Headaches Last?**
 Less Than An Hour From 1-3 Hours Longer Than 3 Hours
 All Waking Hours Several Hours To Days Other: _____
- 9. Do Your Headaches Wake You From Sleep?**
 Yes No Sometimes
- 10. Do Any Of The Following Occur With Your Headaches?**
 Nausea/Vomiting Weakness Tremor Vision Problems
 Dizziness Light/Sound Sensitivity Other: _____
- 11. What Makes Your Headaches Better?**
 Nothing Rest Lying Down Ice Massage
 Standing NSAIDS (Aspirin, Tylenol, etc.) Other: _____

D. OTHER COMPLAINTS

Do You Have Any Other Complaints Not Covered On This Form? Yes No
If Yes, Describe Other Complaints In Detail

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E. REVIEW OF SYMPTOMS

Are You Currently Suffering From Any Of The Symptoms Listed Below?

- | | | | |
|---|--------------------------|--------------------------|---|
| <input type="checkbox"/> None of the Symptoms Listed Below
<input type="checkbox"/> General Fatigue (chronic)
<input type="checkbox"/> Weakness
<input type="checkbox"/> Fever (continuous)
<input type="checkbox"/> Loss of Sleep
<input type="checkbox"/> Chills (continuous)
<input type="checkbox"/> Weight Change (unexplained)
<input type="checkbox"/> Night Sweats
<input type="checkbox"/> Headaches
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Fainting
<input type="checkbox"/> Convulsions
<input type="checkbox"/> Nervousness
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Depression (Prolonged)
<input type="checkbox"/> Phobias
<input type="checkbox"/> Memory Loss
<input type="checkbox"/> Mood Swings (excessive) | <u>Left</u> | <u>Right</u> | <input type="checkbox"/> Other: _____
<input type="checkbox"/> Skin Rash
<input type="checkbox"/> Redness of Skin
<input type="checkbox"/> Skin Itching
<input type="checkbox"/> Skin Dryness
<input type="checkbox"/> Eczema (red, inflamed skin)
<input type="checkbox"/> Hair Changes (unplanned)
<input type="checkbox"/> Nail Changes (unplanned)
<input type="checkbox"/> Bruise Easily
<input type="checkbox"/> Cough (chronic)
<input type="checkbox"/> Wheezing (chronic)
<input type="checkbox"/> Difficulty Breathing
<input type="checkbox"/> Swollen Extremities
<input type="checkbox"/> Blue Extremities
<input type="checkbox"/> Varicosities (visible veins)
<input type="checkbox"/> Rapid Heart Beat
<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Heart Palpitations
<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Decreased Appetite
<input type="checkbox"/> Increased Appetite
<input type="checkbox"/> Abdominal Pain
<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Excess Gas
<input type="checkbox"/> Vomiting (excessive)
<input type="checkbox"/> Diarrhea (excessive)
<input type="checkbox"/> Constipation (excessive)
<input type="checkbox"/> Heartburn/Indigestion
<input type="checkbox"/> Painful Urination
<input type="checkbox"/> Urinary Retention
<input type="checkbox"/> Bed-wetting
<input type="checkbox"/> Irregular Menstruation
<input type="checkbox"/> Painful Menstruation
<input type="checkbox"/> Abnormal Vaginal Bleeding
<input type="checkbox"/> Sterility
<input type="checkbox"/> Impotence
<input type="checkbox"/> Lumps in Breasts
<input type="checkbox"/> Redness/Itching of Breasts
<input type="checkbox"/> Dimpling of Breasts
<input type="checkbox"/> Discharge from Breasts
<input type="checkbox"/> Breast Pain |
| <input type="checkbox"/> Hearing Trouble
<input type="checkbox"/> Ringing in Ears
<input type="checkbox"/> Pain in Ears
<input type="checkbox"/> Ear Discharge
<input type="checkbox"/> Vision Trouble
<input type="checkbox"/> Pain In Eyes
<input type="checkbox"/> Eye Discharge
<input type="checkbox"/> Nose/Sinus Pain
<input type="checkbox"/> Excessive Drainage
<input type="checkbox"/> Nose Bleeds (chronic)
<input type="checkbox"/> Nasal Infections (chronic)
<input type="checkbox"/> Absence Of Smell
<input type="checkbox"/> Mouth Sores
<input type="checkbox"/> Bleeding Gums
<input type="checkbox"/> Enlarged Glands
<input type="checkbox"/> Absence of Taste
<input type="checkbox"/> Abnormal Taste Sensation
<input type="checkbox"/> Tonsillitis/Infected Tonsils
<input type="checkbox"/> Difficulty Swallowing
<input type="checkbox"/> Heat/Cold Intolerance
<input type="checkbox"/> Sugar in Urine
<input type="checkbox"/> Goiter (enlarged thyroid gland)
<input type="checkbox"/> Tremor (shaking) | <input type="checkbox"/> | <input type="checkbox"/> | |

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F. HABITS/ACTIVITIES

What Are Your Current Habits?

Packs/Day

Never <1 1-2 2-3 3-4 5+

Smoking

Glasses/Day

Never <1 1-2 2-3 3-4 5+

Caffeinated Drinks.....

Glasses/Day

Never <1 1-2 2-3 3-4 5+

Alcoholic Drinks.....

Drug/Substance Abuse..... No Yes **If Yes, Discuss With Doctor**

Days/Week

Never <1 1-2 2-3 3-4 5+

Exercise.....

Kinds of Exercise You Do:

- Walking Jogging Cycling Swimming Golf
 Tennis Strength Training Other: _____

G. MEDICAL HISTORY

1. HEALTH CARE

a. **Have You Ever Been To A Chiropractor?** Yes No

b. **Do You Have A Family Physician?** Yes No

Date of Last Physical Exam: ____/____/____

Physician's Name: _____

Address: _____

c. **Have You Been Hospitalized In the Past?** Yes No

Date and Reason for Hospitalization

d. **Have You Ever Had Surgery?** Yes No

Date, Reason, Results of Surgery

e. **Have You Ever Had A Serious Accident/Injury?** Yes No

List Date & Describe Injury:

Auto: _____

Work-Related: _____

Personal: _____

Sports Injury: _____

Other: _____

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f. **Are You Currently Taking Any Vitamins, Minerals or Herbs?** (List Supplements) Yes No

g. **Are You Currently Taking Any Medications?** Yes No
 For What Condition(s) Are You Taking Medications?

Anti-inflammatory (Aspirin, Ibuprofen, Motrin, etc.):

Pain/Analgesics: _____

Anti-Depressants: _____

Muscle Relaxants: _____

Blood Pressure Pills: _____

Antibiotics: _____

Birth Control Pills: _____

Corticosteroids: _____

Other: _____

In The Past Have You Used Any Of The Following?

Birth Control Pills Corticosteroids

h. **Are You Currently Allergic To Any Medications?** Yes No
 List Medications:

i. **WOMEN ONLY:** Yes No

To Your Knowledge, **Are You Pregnant?** Yes No

If Pregnant In Past, Were Pregnancies Normal? Yes No

Are You Seeing An OB-GYN Regularly? Yes No

Number of Births: 1 2 3 4 5 Other: _____

Date of Last Exam: ____/____/____

Physician's Name: _____

2. FAMILY HISTORY

	Cancer	Diabetes	Heart Trouble	Hypertension	Stroke	Kidney Disease	Anemia	Mental Illness	Headaches	Osteoporosis	Arthritis	Scoliosis	Back Problems	Disc Problems	Congenital Defects	Genetic Disease	Other	Deceased
Father																		
Mother																		
Brother																		
Sister																		
Children																		

Describe Others: _____

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3. CONDITIONS OR ILLNESSES

Please Indicate If You Now Have Or Have Had In The Past Any Of The Following Illnesses:

No Current or Previous Conditions/Illnesses

Now Have	In Past		Now Have	In Past	
		Sinus Trouble			Kidney Trouble
		Hay Fever			Urinary Retention
		Allergies			Frequent Urination
		Emphysema			Prostate Trouble
		Tuberculosis			Arthritis
		History Of Infection			Osteoporosis
		Fever (Continuous)			Scoliosis
		Cancer/Tumor			Dislocated Joints
		Diabetes			Spinal Disc Disease
		Visual Disturbances			Bone Fractures (list/dates):
		Dizziness/Fainting			_____
		Epilepsy/Seizures			_____
		Thyroid Trouble			Mental/Emotional Difficulty
		High Blood Pressure			Sex. Trans. Disease
		Low Blood Pressure			HIV
		Heart Trouble			AIDS/ARC
		Pacemaker			Abnormal Weight Gain
		Stroke (date): ___/___/_____			Abnormal Weight Loss
		Aortic Aneurism			Numbness Groin/Buttocks
		Anemia			Other: _____
		Rheumatic Fever			_____
		Polio			_____
		Multiple Sclerosis			Other: _____
		Ulcer			_____
		Liver Trouble			_____

H. OCCUPATIONAL INFORMATION/ACTIVITIES OF DAILY LIVING

1. Are You Right Or Left Handed? Right Left
2. Occupation: _____
3. Hours Per Week: _____
4. How Long Have You Been In This Occupation?
 Years 10 20 30 40 50
 1 2 3 4 5 6 7 8 9
5. Do Your Present Complaints Affect The Number Of Hours You Work Per Day? Yes No

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6. What Is Your Primary Work Position And Location?

Work Position: Work Location:
 Seated Standing Desk Counter Workbench
 Other: _____ Other: _____

7. What Movements Does Your Job Require?

Bending Turning Stooping Twisting
 Walking Repetitive Hand Use Carrying
 Other: _____

8. Does Your Job Involve Lifting?

Never Occasionally Intermittently Frequently Constantly
How Many Pounds? <10 10-25 26-50 51-75 76-100 100+

9. What Best Describes Your Stress Level At Work?

None Minimal Moderate Extreme

10. How Do You Rate Your Physical Activity At Work?

Light Moderate Heavy

11. Do Your Work Activities Aggravate Your Current Complaint(s)?

Yes No If Yes, Explain: _____

Patient's Signature

_____/_____/_____
Date

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Today's Date: ____/____/____

Name: _____

Address: _____

City: _____ State: ____ ZIP code: _____

Home Phone: (____) ____ - ____ Cell/Work Phone: (____) ____ - ____

Social Security Number: ____ - ____ - ____ Date of Birth: ____/____/____

Marital Status: Married
 Single
 Widowed
 Divorced
 Separated

Employer: _____ Occupation: _____

Employer Address: _____

Name of Spouse: _____

Spouse Employer: _____ Occupation: _____

Number of Children: ____ Name(s)/Age(s): _____

Referred to our office by: _____

Insurance Information:

(Please present your insurance card when returning this form and we'll do the rest for you!)

Assignment of Benefits: hereby assign and grant the benefits that I am eligible to receive for professional services rendered in this office to McCracken Chiropractic. I authorize the release of any medical information necessary to process any insurance claims for payment. I understand that I am financially responsible for those charges not paid by my insurance.

Patient's Signature (Guardian if minor)

_____/_____/_____
Date

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Patient: _____ **#:** _____

Today's Date: ____/____/____

A. DATE AND TIME OF ACCIDENT/INJURY

Date: ____/____/____ Time: ____:____ am/pm

B. DESCRIPTION OF ACCIDENT/INJURY

Automobile Crash Workmen's Compensation

Other: Accident Injury _____

C. DESCRIBE IN YOUR OWN WORDS WHAT HAPPENED

D. DETAILS OF AUTOMOBILE ACCIDENT

1. Your Vehicle

a) **Type:** _____

b) **Vehicle Size**

Compact Mid-Size Full-Size Other: _____

c) **What Was Your Location In The Vehicle?**

Driver Front Passenger **Rear:** Left Middle Right

d) **What Damage Did The Vehicle You Were In Sustain?**

Minimal Moderate Extensive Totaled Unsure

2. Other Vehicle

a) **Type:** _____

b) **Vehicle Size**

Compact Mid-Size Full-Size Other: _____

c) **How Did This Vehicle Strike The Vehicle You Were In?**

Heads On From Right From Left Rear Ended

Sideswiped On Left Sideswiped On Right Other: _____

d) **What Damage Did The Other Vehicle Sustain?**

Minimal Moderate Extensive Totaled Unsure

3. Describe Any Other Vehicle(s) To Strike The Vehicle You Were In

4. Were Traffic Citations Issued As A Result Of The Accident?

No Driver Of Your Vehicle Driver Of Other Vehicle You Unsure

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5. Conditions At The Time Of Accident?

- a) **Timing:** Daylight Night Dawn Dusk Other: _____
b) **Road:** Dry Wet Snow Covered Icy Other: _____
c) **Visibility:** Good Fair Poor Other: _____

6. At Moment Of Impact

- a) **Were You Prepared For The Accident?**
No Yes
b) **Were You Wearing A Seatbelt?**
No Yes If Yes: Shoulder Belt Shoulder-Lap Belt Lap Belt
c) **Was The Vehicle Equipped With Headrests?**
No Yes If Yes, Location: Low Middle High Unknown
d) **Did Airbags Deploy?**
No Yes

7. Your Body Positioning

- a) **What Was Your Body Position At Impact?**
Straight Slouched Forward **Rotated:** Left Right
Don't Recall Other: _____
b) **What Direction Was Your Body Thrown?**
Forward/Backwards Sideways Across Vehicle
Outside Vehicle Don't Recall Other: _____

8. Your Head/Neck Positioning

- a) **What Was Your Head/Neck Position At Impact?**
Straight Tilted Forward **Rotated:** Left Right
Don't Recall Other: _____
b) **Through What Motion Were Your Head/Neck Thrown?**
Forward/Backwards Sideways Don't Recall
Other: _____

9. Result Of Impact

- a) **Did The Force Of Impact Cause Your Head/Neck To Strike Anything?**
No Yes If Yes, Then What: _____
b) **Did The Force Of Impact Cause Any Other Part OF Your Body To Strike Anything?**
No Yes If Yes, Then What: _____

E. IMMEDIATELY AFTER THE ACCIDENT

1. Did You Lose Consciousness?

- Yes No Don't Know

2. How Did You Feel?

- Confused Dazed Dizzy Nervous Weak Other: _____

3. Where Did You Immediately Feel Pain?

- Head Neck Upper Back Mid Back Low Back Arms Legs
Other: _____

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4. Did You Receive Emergency Care?

No Yes If Yes, Then Describe Care: _____

5. Destination After Accident/Injury

Hospital Home Work School Other: _____

F. HOSPITAL VISIT AFTER THE ACCIDENT/INJURY

1. When Did You Go?

Immediately Later That Day Next Day Days Later

Other: _____

2. Were X-rays Taken?

Yes No

3. Was A CAT Scan Performed?

Yes No

4. Was An MRI Performed?

Yes No

5. What Was The Diagnosis(es) Given At The Hospital?

6. What Treatment(s) Was/Were Given At The Hospital?

7. What Recommendations Were Made?

G. FOLLOWING THE ACCIDENT/INJURY

1. What, If Any, Additional Symptoms Developed?

2. How Much Later Did Additional Symptoms Develop?

Immediately Hours That Evening Next Morning Days Week

Month Other: _____

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3. Since Your Accident/Injury Have You Suffered From?

- Blurred Vision Double Vision Reduced Vision Impaired Hearing
 Ringing In Ears Chest Pain Difficulty Breathing Palpitations
 Constipation Diarrhea Nausea Vomiting Frequent Urination
 Inability To Hold Urine Painful Urination Anxiety Depression
 Mood Swings Nervousness Poor Memory Tension Convulsions
 Dizziness Headaches Fainting Loss Of Balance Fatigue
 Restlessness Insomnia Light Sensitivity Reduced Appetite
 Weakness Weight Gain Weight Loss Other: _____

4. Has The Accident/Injury Restricted Your Activities?

- No Yes If Yes, Describe: _____

5. Have You Missed Work Due To This Accident/Injury?

- Missed No Work Limited Work Activity
 Missed Work From: ____/____/____ to ____/____/____

6. Did You Self Treat Your Symptoms?

- No Yes If Yes, Then How Or With What: _____

H. INSURANCE/ATTORNEY INFORMATION

1. Have You Contacted An Insurance Adjuster Or Representative Regarding This Claim?

- No Yes If Yes, Company: _____
Adjuster: _____ Claim #: _____

2. Have You Engaged Services Of An Attorney?

- No Yes If Yes, Attorney: _____
Address: _____
City: _____ State: ____ ZIP: _____
Phone: (____) ____ - _____

3. Have You Filed An Accident/Injury Report?

- No Yes

4. Have You Filed For Insurance Benefits?

- No Yes

Patient Or Guardian's Signature

____/____/____
Date

Financial Policy
McCracken Chiropractic & Wellness Center
284 Central Way
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Thank you for choosing us as your health care provider. We are committed to the success of your treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to treatment. If at any time you have questions regarding any treatment, fee, or service, please discuss them with us promptly and frankly. We will make every effort to avoid a misunderstanding or rectify an injustice.

INSURANCE

As a courtesy to you, we will bill your insurance carrier for you. All co-payments, deductibles, and payments for supplements, supports, and other “non-covered” services are due at time of service unless prior arrangements have been made. Payments may be made by cash or check. No Visa, MasterCard, or any other credit/debit cards are accepted. If you are unable to pay in full, it is your responsibility to contact our billing department to set up an agreeable payment plan. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

UCR (USUAL AND CUSTOMARY RATES)

Our practice is committed to providing the best treatment possible for our patients, and we charge what is usual and customary for our area. You are responsible for payment in full, regardless of any insurance company’s arbitrary determination of usual and customary rates.

INJURIES/ACCIDENTS INVOLVING LITIGATION

We will make every effort to recover our fees from all available sources, including your health insurance and any med-pay benefits that are available on your auto insurance policy. We will then wait to collect any unpaid balances until after a settlement is reached. It must be understood, however, that the payment of the balance is ultimately your responsibility.

WORKER’S COMPENSATION

Our office will file worker’s compensation claims. It is your responsibility to contact your employer to establish a worker’s compensation claim. If the claim is denied, we will bill your personal health insurance carrier. If the claim is unsettled or unpaid within 90 days, you will receive a statement from our office.

MINOR PATIENTS

An adult must accompany the minor at the time of the first visit. The adult accompanying the minor is responsible for payment of the account.

MEDICARE

We accept Medicare assignment. We will also file the claim to any secondary insurance that you may have.

MISSED APPOINTMENTS

Missed appointments are not something we will ever bill you for! We understand that things come up and that some of us “forget” occasionally. All that we ask is a common courtesy phone call to reschedule your appointment.

PATIENT STATEMENT

I have read and understand the Financial Policy of McCracken Chiropractic & Wellness Center. I understand that I am ultimately responsible for the payment of any services or products received at this office. I also understand that I will be responsible for any fees related to collecting my unpaid balance, including reasonable attorney fees.

Signed _____ Date ____/____/_____
(Patient or Guardian if patient is under 18 years of age)

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Notice of Privacy Practices: This Notice of Privacy Practices describes how we may collect, use and disclose your personal information, and your rights regarding that information. Under the Health Insurance Portability and Accountability Act of 1996, health care providers must take measures to protect the privacy of your personal information. We are required by law to:

- Protect the privacy of personal information.
- Provide this Notice explaining our duties and privacy practices.
- Abide by the terms of this notice.

Ways We Protect Your Personal Information: We allow only McCracken Chiropractic & Wellness Center staff access to the records and use personal information only to the extent necessary to conduct the practice of healthcare services. We secure the building, patient charts and computer records each day after work. We train our staff on our written confidentiality policy and procedures and employees are subject to discipline if they violate them. We will protect your privacy even if you no longer are a patient here. We shred old documents prior to discarding them.

How We Collect Your Personal Information: We collect the information from you in our initial Patient Information and Health History forms. We may also collect information regarding previous chiropractic treatment and medical conditions from health care providers you have seen in the past.

How We Use Your Personal Information: We use your information to determine appropriate care during your treatment here. We use personal information we collect here (i.e., X-ray records, charting information) to determine what chiropractic treatment we will provide. We may share this information with other chiropractic specialists to help determine your treatment. We use Social Security numbers, birth date and employer information to identify you with health care insurance groups. We use phone numbers and addresses to communicate with you regarding appointments and billing for services. Unless you request us not to, we may discuss your information with immediate family, i.e., with a spouse, also we discuss dependent's treatment with parents. We may be ordered by the Court in some unusual situations to release information and do so if it is required.

Your Rights: You may inspect records we retain regarding personal information and amend them if you feel they are in error. You may request we restrict the sharing of your information except on a case-by-case basis. You may request we only contact you at specific locations, i.e. only at work. You may also request records; we may charge a reasonable fee for this service. You may ask questions regarding your Personal information here.

Patient acknowledgement of Privacy Practices: I have seen the Privacy Practices notice as required by HIPAA, have read it and been given the opportunity to ask questions.

Patient Signature: _____ Date: ___/___/_____