

# Your Life Review *Bremerton Wellness*

## Welcome to our Office

Name: \_\_\_\_\_ Home: \_\_\_\_\_ Cell: \_\_\_\_\_  
Work: \_\_\_\_\_ Fax #: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
Zip: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Who can we thank for your referral: \_\_\_\_\_

Ins. Name: \_\_\_\_\_ Ins. ID#: \_\_\_\_\_  
Secondary Ins. Name: \_\_\_\_\_ Ins. ID# \_\_\_\_\_  
Do you have a Health savings account yes  no  or do you have Flex benefits program yes  no

**Give a brief detailed description of the problem you are currently experiencing:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long have you had this condition? \_\_\_\_\_ is it getting worse? \_\_\_\_\_  
Does it affect your (check appropriate boxes):  work,  sleep,  other: \_\_\_\_\_  
Treatment received in the past? \_\_\_\_\_

### Please check all your warning signs even if not seemingly related to your complaint.

- |   |                                  |  |  |   |
|---|----------------------------------|--|--|---|
| <input type="checkbox"/> frequent colds                                 | <input type="checkbox"/> anxiety | <input type="checkbox"/> diabetes                                    | <input type="checkbox"/> bed wetting                             | <input type="checkbox"/> Ringing in Ears              |
| <input type="checkbox"/> cold hands/feet                                | <input type="checkbox"/> ulcers  | <input type="checkbox"/> incontinence                                | <input type="checkbox"/> mood swings                             | <input type="checkbox"/> Breathing problems           |
| <input type="checkbox"/> bowel problems                                 |                                  | <input type="checkbox"/> poor awakening                              | <input type="checkbox"/> panic attacks                           | <input type="checkbox"/> Shoulder pain                |
| <input type="checkbox"/> constipation                                   |                                  | <input type="checkbox"/> low pain threshold                          | <input type="checkbox"/> fevers <input type="checkbox"/> fatigue | <input type="checkbox"/> Elbow pain                   |
| <input type="checkbox"/> diarrhea                                       |                                  | <input type="checkbox"/> headaches <input type="checkbox"/> seizures | <input type="checkbox"/> MS <input type="checkbox"/> Vertigo     | <input type="checkbox"/> Wrist/Hand pain              |
| <input type="checkbox"/> high BP <input type="checkbox"/> tight muscles |                                  | <input type="checkbox"/> narcolepsy <input type="checkbox"/> PMS     | <input type="checkbox"/> Epstein-Barr syndrome                   | <input type="checkbox"/> Hip pain                     |
| <input type="checkbox"/> heart palpitations                             |                                  | <input type="checkbox"/> sleep walking                               | <input type="checkbox"/> Fibromyalgia                            | <input type="checkbox"/> Knee pain                    |
| <input type="checkbox"/> ADD  |                                  | <input type="checkbox"/> hot flashes                                 | <input type="checkbox"/> depression                              | <input type="checkbox"/> Ankle/Foot pain              |
| <input type="checkbox"/> low energy                                     |                                  | <input type="checkbox"/> allergies                                   | <input type="checkbox"/> Rheumatoid arthritis                    | <input type="checkbox"/> Auto-immune system disorders |
| <input type="checkbox"/> sinusitis                                      |                                  | <input type="checkbox"/> IBS   | <input type="checkbox"/> Chronic fatigue synd.                   | <input type="checkbox"/> Balance issues               |
| <input type="checkbox"/> arm/ leg weakness                              |                                  | <input type="checkbox"/> eating disorders                            | <input type="checkbox"/> TMJ (Jaw Pain)                          |   |

**List current medications:**  
\_\_\_\_\_  
\_\_\_\_\_

### List of injuries: (ex: falls, sports injuries, repetitive stress injuries)

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Ever been in any motor vehicle accidents? (please note type and year, even if not apparently injured) \_\_\_\_\_

Any surgeries? \_\_\_\_\_  
Have you received Chiropractic care before? yes  no   
If yes, Name of Chiropractor-Dr: \_\_\_\_\_, Location: \_\_\_\_\_  
Have you received acupuncture care before? yes  no  If yes, list location: \_\_\_\_\_  
Have you seen a naturopath physician? yes  no  If yes, Dr. \_\_\_\_\_ list location: \_\_\_\_\_  
Name of Medical Provider-Dr: \_\_\_\_\_, Location: \_\_\_\_\_

### Agreements

The statements made on this form are accurate, to the best of my recollection, and I agree to allow this office to do an examination of me for further evaluation.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Office Use Only  
O2: \_\_\_\_\_  
P: \_\_\_\_\_  
Ht: \_\_\_\_\_

# *Bremerton Wellness*

List current over the counter medications and nutritional supplements

---

---

---

---

---

## **FAMILY MEDICAL HISTORY**

**F=Father M=Mother H=Husband W=Wife K=Kid(s) S=Sibling G=Grandparent**

Place the appropriate letter(s) in the blank of someone in your family has/had any of the following:

- |  |  |
|--|--|
| _____ <b>Allergies</b> (Hay fever, Food Allergies, etc.)                 | _____ <b>Foot/Ankle Pain</b>                     |
| _____ <b>Anxiety</b>   | _____ <b>Headaches</b> (Migraines, Tension, etc) |
| _____ <b>Arthritis/Joint Disease</b>                                     | _____ <b>High Blood Pressure</b>                 |
| _____ <b>Asthma/Breathing Problems</b>                                   | _____ <b>High Cholesterol</b>                    |
| _____ <b>Bed Wetting</b>   | _____ <b>Knee Pain</b>                           |
| _____ <b>Bursitis</b> (Shoulder, Hip, etc)                               | _____ <b>Lower Back Pain</b>                     |
| _____ <b>Cancer</b> - type? _____  | _____ <b>Neck Pain</b>                           |
| _____ <b>Carpal Tunnel Syndrome</b>                                      | _____ <b>Numbness/Tingling</b>                   |
| _____ <b>Depression</b>  | Where? _____                                     |
| _____ <b>Diabetes</b> - type? _____                                      | _____ <b>Osteoporosis</b>                        |
| _____ <b>Digestive Disorder</b> (GERD/Reflux, Ulcers, IBS, Crohn's, etc) | _____ <b>Plantar Fasciitis</b>                   |
| _____ <b>Ear Infections</b> (repeated/chronic)                           | _____ <b>Sciatic Pain/Sciatica</b>               |
| _____ <b>Fatigue/Low Energy</b>  | _____ <b>Shoulder Pain</b>                       |
| _____ <b>Fibromyalgia</b>  | _____ <b>TMJ/Jaw Pain</b>                        |
|  | _____ <b>Upper Back Pain</b>                     |

**Please check any of the following services you would like more information about:**

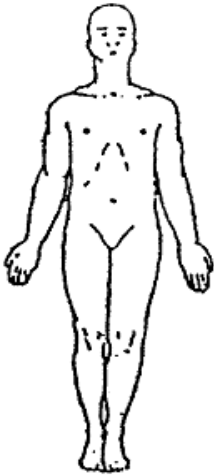
- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Medical Weight Loss       | <input type="checkbox"/> Acupuncture                | <input type="checkbox"/> Nurse Practitioner |
| <input type="checkbox"/> Knee Regeneration Therapy | <input type="checkbox"/> Decompression Disc Therapy | <input type="checkbox"/> Migraine Therapy   |
| <input type="checkbox"/> Peripheral Neuropathy     | <input type="checkbox"/> Fibromyalgia Treatment     | <input type="checkbox"/> Massage            |
| <input type="checkbox"/> Allergy Testing           |   |   |

**Bremerton Wellness**  
**Joint/Pain Evaluation Chart & Questionnaire**

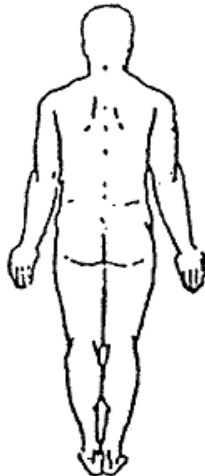
Name: \_\_\_\_\_

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

**Primary Onset (check one)**  Chronic issue,  Sports injury,  Car accident,  Work injury



**Front**



**Back**



**Right**



**Left**

**Indicate the location of pain/ discomfort above. Use the symbol that best describes the feelings:**

**XXX** sharp/ stabbing

**PPP** pins/needles

**DDD** dull/aching

**NNN** numbness

**Leg pain** – numbness / tingling    **Arm pain** – numbness / tingling    **Weakness** – numbness / tingling

**Daily living Questionnaire**

What type of work do you do? \_\_\_\_\_ Hours per day? \_\_\_\_\_

Hours per day prior to pain/discomfort? \_\_\_\_\_

How is your work affected? \_\_\_\_\_

**Home & Family** list the activities affected by your exacerbation:

\_\_\_\_\_

**Sleep:** How many hours of sleep per night do you sleep now? \_\_\_\_\_ prior \_\_\_\_\_

Do you feel your sleep is affected? If yes, explain briefly

\_\_\_\_\_

**Social/Recreational:** Activities \_\_\_\_\_

How are your current activities affected? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# Bremerton Wellness

## FINANCIAL POLICIES AND AGREEMENTS

Because clarity about financial matters is essential for you to receive optimum benefit from your care, we have outlined our financial policies and agreements below. Please read carefully and sign or initial where indicated.

I, \_\_\_\_\_, understand and agree to the following:

(Print your name)

A. I am solely responsible for the expenses of my care and/or the care of my dependents. While I may assign payment of benefits to Bremerton Wellness (BW), any uncovered services, deductibles, and co-payments are my financial obligation, to the extent allowed by the terms of the KCW's provider contracts with insurance plans. *(While most insurance plans cover chiropractic, massage, acupuncture, medical, naturopathic medicine your health and accident policies are a contract between you and your insurance company. We are happy to prepare any necessary reports and forms to assist you in making collection from your insurance company. See our Fee Schedule for current fees. Prices are subject to change.)*

### B. INSURANCE NON-COVERED SERVICE DISCLOSURE AND AGREEMENT

1. Potential reasons for non-covered status include: The service is or may be deemed (a) investigational or experimental under the carrier's internal guidelines; (b) not medically necessary under the carrier's internal care or cost management guidelines; (c) not actually covered under the plan to which you are subscribed; (d) 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.
2. 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.
3. I acknowledge that the Non-Covered status of the proposed service(s) has been explained and that a certain portion of my care may not be covered by or has not been authorized by my insurance plan. If any portion of the care provided is not, or may not be covered by insurance, then I shall be responsible for payment and shall make the necessary financial arrangement with the healthcare provider to pay for these services. \_\_\_\_\_

(Initial)

C. **ASSIGNMENT AND GROUP ACCIDENT AND HEALTH INSURANCE:** *See attached form.* Any amount authorized to be paid directly to Bremerton Wellness will be credited to your account upon receipt.

D. **CHOICE OF PAYMENT OPTIONS:** We are happy to provide the following payment options. If you are choosing to use your insurance you will need to pick a second option for any services not covered by your insurance.

1. Insurance Coverage: coverage varies with individual plans; generally only a portion of the recommended care plan will be covered.
2. Cash/Credit Per Visit: includes money orders, personal checks, credit and debit cards; generally a 20% discount applies; see attached Fee Schedule for details.
3. Payment Plans: monthly or yearly payment plans are available with an approximate savings of 25-30%. Care Credit Card: A zero-or-low-interest health care credit card which you may apply for and use here in our office upon your request.

Please circle your two choices above and initial here \_\_\_\_\_

E. **AUTHORIZATION FOR TAKING AND RETAINING X-RAY FILMS:** I hereby authorize the taking of analytical x-ray films by the doctors, clinic, and/or staff of Bremerton Wellness, of such areas as may be of anatomical interest and which may be recommended from time to time by the doctor(s). Further, I agree that the doctor(s)/clinic shall be the sole owner of such analytical films and shall remain in custody and in control of said films, until such time as I shall sign a Release Form stating otherwise. Such form will be provided by Bremerton Wellness, P.S., upon request. (See signature below and initials here: \_\_\_\_\_.)] [Females only: I state that I am not pregnant. (See signature below and initials here: \_\_\_\_\_.)]

\_\_\_\_\_  
Patient (or Parent/Guardian) Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Bremerton Wellness Signature

\_\_\_\_\_  
Date

*Bremerton Wellness*

# Consent for Care

(Please read, initial & sign below)

I, [redacted] (the patient or guardian), grant permission to Bremerton Wellness to perform examinations and procedures as may be professionally deemed necessary or advisable for me as patient this may include one or more of the following:

**Chiropractic adjustment:** this specific application of forces to facilitate the body's correction of vertebral subluxation. Vertebral subluxation is the misalignment of nerve impulses, resulting in lessening of the body's innate ability to achieve its maximum health.

**Acupuncture:** a technique of oriental medicine that includes the insertion of fine, sterile needles at specific points along the body. Acupuncture meridians or channels are pathways through which the body's vital energy flows throughout the body. The points lie along the meridians and provide gateways to influence, redirect, increase or decrease the body's vital substance (qi and blood) thus correcting many of the body's imbalances.

**Massage:** massage techniques manipulate the muscles of the body increasing your range of motion and eliminates the body of any toxic waste. It aids in stress relief, increases circulation, and releases endorphins which enhances pain relief.

**Medical/Nurse Practitioner:** Nurse Practitioners at Bremerton Wellness provide a wide range of natural pain modalities such as Stem Cell therapy; Platelet Rich Plasma; trigger point injections and IV therapy.

**Rehab Therapy:** This may include rehabilitative exercises; home care stretches; NeuroCare; Laser Therapy and will be performed by trained team members at Bremerton Wellness.

I do not expect the doctor(s) or licensed practitioner(s) to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor(s) or licensed practitioner(s) to exercise judgment during the course of treatment which the doctor/practitioner feels at the time, based upon the facts then known to him or her, is in my best interest. [redacted] (initial)

I have read the explanation above of the treatments/ services offered at Bremerton Wellness, I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing care and treatment. I have freely decided to undergo the recommended care and treatment, and hereby give my full consent to care and treatment here. [redacted] (initial)

[redacted]  
Patient/ Responsible party signature

[redacted]  
Printed Name

[redacted]  
Date

\_\_\_\_\_  
Bremerton Wellness Staff

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

# *Bremerton Wellness*

## **Consent for Purposes of Treatment, Payment and Health Care Operations**

I consent to the use or disclosure of my protected health information by Bremerton Wellness for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Bremerton Wellness. I understand that diagnosis or treatment of me by the treating provider 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. Bremerton Wellness is not required to agree to the restrictions that I may request. However, if Bremerton Wellness agrees to a restriction that I request, the restriction is binding on Bremerton Wellness. I have the right to revoke this consent, in writing, at any time, except to the extent that Bremerton Wellness 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 the right to review Bremerton Wellness’s Notice of Privacy Practices prior to signing this document.

Bremerton Wellness’s Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices describes the type 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 Bremerton

The Notice of Privacy Practices for all treating providers is also provided at the front desk of Bremerton Wellness.

This Notice of Privacy Practices also describes my rights and the duties of Bremerton Wellness with respect to my protected health information.

Bremerton Wellness 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 of Personal Representative’s Authority

# Patient Cancellation Policy

**Our intent is to ensure patients are able to get the most out of their treatment.** No Shows and Late Cancels prohibit other patients from receiving treatment because appointment times have been reserved and then wasted when someone does not show up or late cancels an appointment.

We respectfully ask that if you are unable to make it to your appointment as scheduled, **please cancel at least 24 hours prior to the start of your appointment time.**

You can cancel your appointment time by calling our office.

**360-627-7408**

## **Two Late Cancels / No Shows will result in the following:**

1. You must prepay future appointments
2. Only schedule for day-of openings

**As always, our team is here to create the best experience for all of our patients. Please let us know if you have any questions.**

Kind Regards,  
Your Bremerton Wellness Team

**Please note:** if you sign up on massage wait-list you will receive a text and call notification if we have any last-minute day-of massage openings

*\*Late Cancellation is when an appointment is canceled less than 24 hours before appointment time begins.*

Patient Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

## Massage Notice

Regrettably, due to the excessive amount of repeat **NO SHOWS** and **LAST-MINUTE CANCELATIONS (within 24 hrs)** we will be charging a **\$25.00** FEE.

However, if we *are able to fill the time slot*, then there will be NO FEE 😊. So, the sooner you notify us that you're unable to make your appointment, the better chance we're able to fill the time slot.

To enforce this policy, we will be saving a credit card on file. By signing this notice, you are agreeing to the policies above.

Thank you for your understanding.

---

Patient's signature

---

Date

---

Printed Name