Welcome to Advanced Health Chiropractic and Massage.
Please take a few moments to fill out this questionnaire.
This will help us to serve you better.

Last Name: _____ First Name: _____
Address: _____ Birthday: _____
City/State: _____ Zip Code: _____
Email Address: _____
Cell Phone: _____ Home Phone: _____
Type of Employment: _____ Hours Per Day/Week: _____
Emergency Contact: _____ Phone #: _____
Recent Surgeries: _____ Prescriptions: _____
Primary Physician: _____ Phone #: _____

Have you been in a Car Collision or Accident at Work within the last year? NO YES
If yes – See Front Desk Now

Today I would like to focus on:
- □ Full Body
- □ Neck
- □ Upper Back
- □ Shoulders
- □ Arms
- □ Hands
- □ Lower Back
- □ Hips/Gluteal Region
- □ Legs
- □ Feet
- □ Other_____

Purpose of Today's Visit:
- □ Health and Wellness
- □ Relaxation
- □ Stress
- □ Pain
- □ Injury
- □ Headache
- □ Other _____

Desired Pressure:
□ Light □ Firm □ Deep

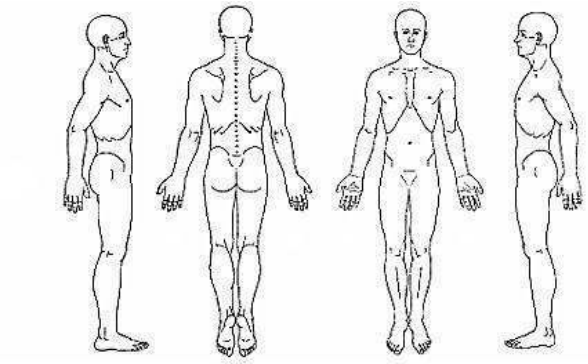
Is this a New Injury?
□ Yes □ No

If possible would you like to extend your appointment length?
- □ 30 Mins (90 Mins total) $25
- □ 60 Mins (120 Mins Total) Prices Vary based on Plan

What other things have you tried to resolve your condition?

□ Physical Therapy	□ Personal Training
□ Acupuncture	□ Massage
□ Chiropractic	□ Cold Laser
□ Medical Doctor	□ Infrared Sauna

Please mark where you experience pain:



Are you experiencing Numbness or Burning?
NO YES

What aggravates this pain? _____

What relieves this pain? _____

Medical Information:
- □ Allergies to Oils/lotions
- □ High/Low Blood Pressure
- □ Heart Condition
- □ Contact Lenses
- □ Infectious Disease
- □ Broken Bones
- □ Scoliosis
- □ Bursitis
- □ Skin Condition
- □ Varicose Veins
- □ Arthritis
- □ Impetigo
- □ Cancer
- □ Seizure
- □ Skin Disorder(s)
- □ Diabetes
- □ Stroke
- □ Pregnant
- □ Epilepsy
- □ Migraine
- □ Other: _____

What Type of Pain:
- □ Pinching
- □ Tingling
- □ Numbness
- □ Aching
- □ Radiating
- □ Other: _____

Covered/Non-Covered Services

I understand that the services rendered and/or supplies/aides given to me may not be considered eligible for benefits (eg. Services and/or supplies/aides may be determined to be not medically necessary, non-covered or investigational) by my health insurance company. I understand that my health insurance coverage has certain restrictions and limitations, such as authorization requirements, and non-covered services and/or supplies/aides. Since I have chosen to obtain the services and/or supplies/aides, I agree to be financially responsible for any and all related charges, if they are not covered by my insurance. Your treatment plan makes it necessary to utilize not only Chiropractic Care codes, but to also utilize what is best described as Physical Therapy codes. Policy benefits for both areas of care vary greatly by insurance policy and we cannot be aware of each person's specific policy benefits. To provide our best level of care, we provide a treatment plan that is specific for you and not based on your insurance policy benefits. Your specific policy benefits will determine what your patient responsibility will be. Our office will not quote insurance benefits; therefore, you are encouraged to contact your health plan. If you are unsure of your insurance benefits or your deducible, a charge of $45 will be applied for each date of service until benefits can be determined by your insurance carrier. These monies will be placed on your account towards any out of pocket expenses as determined by your insurance plan.

Billing and Payments

You, the patient or legal guardian, are responsible for all claims made to your insurance. Billing is a courtesy service which we provide to our patients at no extra charge. In the event of the insurance plan's denial of benefits or claim payments, the patient is responsible for the total balance due to the provider. If the insurance carrier requires the patient to send in more information regarding his/her claim and the patient fails to return the required information to the carrier, the patient will be billed for the entire balance on the claim, as the insurance company requires the provider to do. All co-pays and known co-insurance amounts are due at the time of service. In the event you do not have health insurance coverage, we do offer a Time of Service reduction of our fee schedule. This reduced fee must be paid at time of service in order to receive the reduction; if payment is not received on the same date of service, then our regular fee schedule rates will be applied. All outstanding unpaid patient account balances over $75 will result in the inability for the patient to schedule future appointments, until the patient portion of the account is paid.

Patient Statements

Patient statements are sent out on the 10th of each month for the previous months billing and payment activities. Payments on your account are due by the last day of the month in which the statement was sent. Patients are given 90 days to make payments on account before sent to pre-collections. If at any time a payment cannot be made, please call our office to set up a payment plan or inform the clinic of your situation as you may qualify for deferred payments. All accounts with patient portion balance showing no patient payment activity will be charged a $10 monthly Account Maintenance Fee, for each month no payment is made on the account. A $5 paper statement fee will be added to all statements sent out, unless enrolled in our Automated Billing System.

Reminders/Missed Appointments

With the exception of emergencies, it is vital that you keep all your appointments. Reminder cards, emails and text messages are available to help you save the date and time of your appointments. If you need to reschedule and appointment, please call our office within 24 hours of you appointment time to cancel and reschedule. In the instance of a last minute reschedule or No Show appointment, we reserve the right to charge you a $25 fee.

Payment Methods

We accept Cash, Check, Visa, MasterCard and Discover; however anytime your Debit or Credit Card is swiped we charge a $3 processing fee. Our Wellness programs on Auto-Debits are excluded from this processing fee.

Statement of Privacy

We use and disclose the information we collect from you only as allowed by Health Insurance Portability and Accountability Act and Washington State. This includes issues relating to your treatment, payment, and care operations. Your personal health information will never be otherwise given to anyone without your written consent. You may give written authorization for us to disclose your information to anyone you choose, for any purpose. Our office and systems are secure from unauthorized access and our team is trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients. We will only request personal information needed to provide our standard of quality chiropractic or massage care, implement payment activates, conduct normal business operations, and comply with the law. This includes name, address, phone numbers, SSN, employment date, medical history, health records, etc. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We may use and/or disclose your information to communicate reminders about your appointments including text messaging, voicemail messages, and mailings. You have a right to request copies of your healthcare information; all requests must be in writing. We may charge for copies in the amounts allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the US Dept of Health and Human Services.

Terms of Acceptance

When a patient seeks chiropractic care, it is essential for both patient and clinic 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 used to attain it. This will prevent any confusion or disappointment. An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Vertebral Subluxation is a misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve 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 diagnose or 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 service of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding the 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. All questions pertaining to my care in the clinic have been answered to my satisfaction. I therefore accept care on this basis.

Date

Printed Name

Signature

ADVANCED HEALTH
CHIROPRACTIC AND MASSAGE

WHAT YOU MAY EXPECT AFTER YOUR MASSAGE

- A STATE OF WELL BEING OR RELAXED
- MUSCLE SORENESS
- BRUISING (WITH DEEP TISSUE)
- THIRSTINESS

INSTRUCTIONS FOR AFTER YOUR MASSAGE

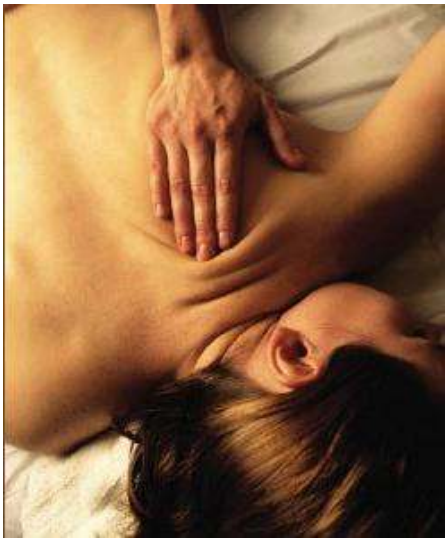
- DOUBLE YOUR WATER INTAKE
  (REFRAIN FROM ALCOHOL OR CAFFIENE)
- ICE IF SORE
  (TYPICALLY AFTER DEEP TISSUE)
- SOAK IN EPSOM SALT BATH
  (AFTER DEEP TISSUE OR THERAPEUTIC WORK)
- PLACE HEAT ON AREA IF TIGHTNESS RE-OCCURS
- MAY USE SOMBRA OR BIOFREEZE TO COOL DOWN

ASK FOR THESE PRODUCTS

- EPSOM SALT
- SOMBRA
- BACK SUPPORTS
- ICE/HEAT PACKS

ARE YOU PART OF OUR Wellness ?

BECOME A MEMBER TODAY, ASK YOUR THERAPIST.



10709 N. Division
Spokane, WA 99218

Phone:509.466.9008
Fax: 509.466.0175

Web: RUBCLUBSPOKANE.COM