Patient Information Today's Date: _____

Name _____ Age _____ Gender: M F (Pregnant: Y N)
Home Address _____ Home Phone _____
City, State, Zip _____ Cell Phone _____
Email Address _____
Birth date _____ Social Security Number _____ Marital Status: S M D W P
Occupation, Employer _____ How many people in your household? ____
Emergency Contact _____ Phone _____
How were you referred to this office? _____
Who is your Primary Care Doctor? _____

Is This Visit Related To A: (Please Circle)

Work Injury Car Collision Injury Home Injury Non-Injury Symptoms Gradual Onset Other

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 _____

Are you experiencing Numbness or Burning?
NO YES

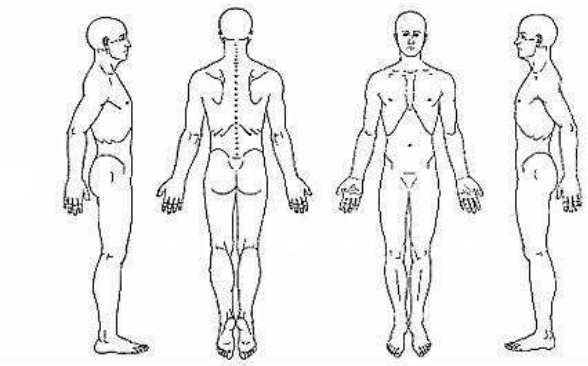
Desired Pressure:
□ Light □ Firm □ Deep

Is this a New Injury?
□ Yes □ No

If possible would you like to extend your appointment length?
- □ 30 Mins (90 Mins Total) $35
- □ 60 Mins (120 Mins Total) Price Varies

What other things have you tried to resolve your condition?
- □ Chiropractic □ Massage
- □ Physical Therapy □ Personal Training
- □ Medical Doctor □ Other

Please mark where you experience 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-Left Arm: Yes No
- □ Numbness
- □ Aching
- □ Radiating
- □ Other: _____

What aggravates this pain? _____

What relieves this pain? _____

Patient Signature: _____ Date: _____

Patient Name:

We would like to take a moment to welcome you to our clinic and assure you that you will receive the very best of care available for your condition. The following are our clinic financial policies please familiarize yourself with our policies, please initial each section. If you have any questions, please contact the front desk. Thank You

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 Rehabilitation 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. **It is ultimately your responsibility to check with your insurance to understand the contract and coverage.**

If you are unsure of your insurance benefits or your deducible, a charge of $50 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.

____ PLEASE INITIAL AFTER READING

Primary Insurance Company: _____

Member ID #: _____

Group #: _____

Secondary Insurance Company: _____

Member ID #: _____

Group #: _____

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. This office will provide any necessary reports or required information to aid in insurance reimbursement of services. 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 to your account.

All outstanding unpaid patient account balances over $100 will result in the inability for the patient to schedule future appointments, until the patient portion of the account is paid, or payment arrangements are made.

If an account is delinquent for more than 60 days, we reserve the right to charge a 1.75% interest rate per month, an annual rate of 21%.

____ PLEASE INITIAL AFTER READING

Patient Name:

Assignment of Benefits

By signing this form you are authorizing payment of medical benefits will be made directly to this office. If your insurance carrier sends payment to you for services incurred in this office, you agree to send or bring those payments to this office upon receipt. However if you pay for your visits in full the assignment will not be reported by this provider and any payment will be send directly to you.

____ PLEASE INITIAL AFTER READING

Payment Methods

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

____ PLEASE INITIAL AFTER READING

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.

Our patient's, staff and doctor's time is valuable, and we wish to provide every patient with an excellent experience. Please provide us the courtesy of a **48 hour cancellation** or change notice if you are unable to keep your appointment time. A $25 missed appointment fee will be charged for a no call, no show appointment, or an appointment change without 48 hour notice.

____ PLEASE INITIAL AFTER READING

Credit Card Authorization

A credit card will remain on file for the purpose of missed appointments. The credit card will not be charged for any other services without the permission of the patient. This information will be kept confidential and stored per HIPAA regulations.

Card Number: _____ Expiration Date: _____ CVC: _____

____ PLEASE INITIAL AFTER READING

Patient Statements

Patient statements are sent out monthly 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.

____ PLEASE INITIAL AFTER READING

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. We thank you for being a patient at our office.

____ PLEASE INITIAL AFTER READING

Release of Information

If we bill your insurance company, and you insurance company requires medical reports or records to document your treatment or progress, your signature below authorizes this office to release the medical information necessary to process your claim.

If you pay at the Time of Service and insurance is not billed by our clinic, then your signature below verifies that our clinic will not bill insurance for any services rendered and in turn your health insurance company will not be able to request medical records for services rendered.

____ PLEASE INITIAL AFTER READING

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. The doctor and/or his staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care provider, or are not related to the spinal structural conditions diagnosed at this clinic.

____ PLEASE INITIAL AFTER READING

Arbitration Agreement

It is understood that any dispute as to medical malpractice, including whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration proceedings. Both parties to this contract are accepting the use of arbitration.

____ PLEASE INITIAL AFTER READING

Patient Printed Name: _____ Date: _____

Patient Signature: _____