BACK & NECK CARE CHIROPRACTIC

Confidential Patient Information

All information will be kept strictly confidential. Your responses will help determine if chiropractic, acupuncture or massage will benefit you. Unless we sincerely feel that your condition will respond satisfactorily, we will not recommend treatment.

Patient Information

Name_____
Address_____
_____
City State Zip Code
Home Phone (____)_____
Cell (____)_____
Social Security Number_____
Birthdate_____ **Age**_____ **Sex:** ☐M ☐F☐Other ☐Withheld
Current Height:_____/ **Weight:**_____
☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced
Occupation_____
Employer_____
Employer Address_____
Work Phone (____)_____
Spouse's Name_____
Spouse's Occupation_____
Number of Children: _____
Race: Asian/Pacific Islander, Black or African American, Caucasian, Hispanic or Latino, Native American, Withheld
Ethnicity: Non-Hispanic, Hispanic, Withheld
Who may we thank for referring you?
Advertisement/ Insurance / Web / Friend or Family?
NAME: _____

Accident Information

Is condition due to an Accident? ☐Yes ☐ No
Date of Accident_____
Type of Accident ☐ Auto ☐ Work ☐ Home ☐ Other _____
To whom have you reported the Accident?
☐ My Auto Insurance ☐ Third Party's Auto Insurance
☐ Employer ☐ Worker's Comp ☐ Other _____
Attorney Name (if applicable)_____
Attorney Phone number _____

Please provide your medical doctors contact information, we would like to personally report the status of your health condition to them.
Doctors name: _____ MD / DC / DO
Clinic/Group_____
Address: _____City, State, Zip: _____
Phone: _____

Emergency Contact

In case of an emergency, whom may we contact?
Name_____ Phone_____
Relationship_____ Work Phone_____

Email/Text Correspondence

If you would like to receive text or e-mail alerts for your upcoming appointments, please provide the following information. You may unsubscribe at any time by contacting our office.

Email Address: _____
Cellular Provider(AT&T, Sprint, Verizon, etc): _____

Your security is our first priority. We have a strict do-not-sell policy that we take very seriously. No one else has access to your personal account information, subscriber details, or contact list.

Are you Pregnant? ☐ Yes ☐ No
Due Date _____
Do you have:
High Blood Pressure ☐ Yes ☐ No
Pacemaker ☐ Yes ☐ No
Cardiac or Circulatory Problems ☐ Yes ☐ No
Do you bruise easily ☐ Yes ☐ No
Infectious Disease ☐ Yes ☐ No

Consent To Treat

I hereby authorize the doctor(s) or other providers of this clinic and whomever they may designate as their assistants to administer treatment as they so deem necessary.
I, also authorize the release of information about my physical condition to my insurance company and/or attorney in order to process my bills for payment. I give permission to share private and medical information with my Medical Doctor as well as his/her staff. They have permission to share private and medical information with this office as it pertains to my health care.
I certify that the above information is true and correct.
I understand that I am ultimately responsible for all bills occurred. When/If Insurance benefits are quoted, it is not a guarantee of payment, claims will be reviewed at the time they are received. As a courtesy to our patients we provide complimentary insurance billing. However, we are not responsible for claim status and processing.

Signature of Patient (or Patient's Guardian):
Name:_____ Date:_____

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What Are Your Complaint(s)?: _____

_____

_____

_____

Are there ASSOCIATED SYMPTOMS with Complaint(s)?

- Fatigue, Headache, Morning Stiffness,
- Numbness Radiating to Arms-Legs,
- Are there any Bowel or Bladder issues?

What is the QUALITY OF YOUR PAIN?:

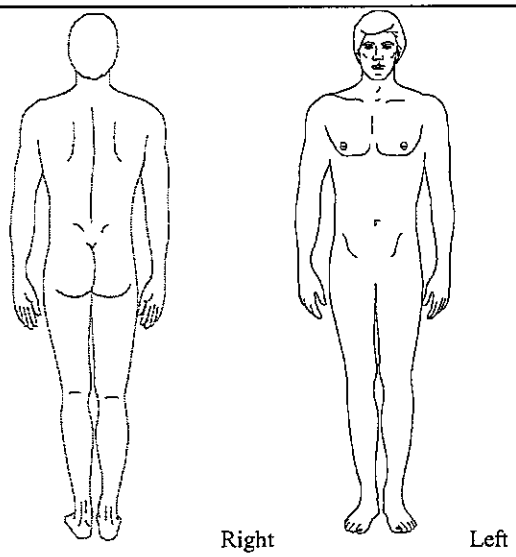
- Aching, Burning, Dull, Intermittent, Shooting, Stabbing, Throbbing, _____
- Headache is Worst Ever
- Decreasing, Improving, Worse,

What is the SEVERITY of Your Complaint?:

- **MILD, MODERATE, SEVERE**
- What Activities does this Interfere with: Household Activities, Normal Lifestyle, School, Sleeping, Work, Sex, Sports, Finances, Playing with Kids, _____
- **PAIN LEVEL**: No Pain = **0- 1- 2- 3- 4- 5- 6- 7- 8- 9- 10**

Please MARK your Areas of Pain

A=Aching / B=Burning / S=Stabbing / P=Pain
N = Numbness / T = Tingling /
W = Weakness



What is the DURATION of Your Complaint?:

- Length of Time this Episode has been Present? _____ Days / Months / Years

What is the TIMING of Your Complaint?: Symptom **Onset** was: Abrupt, Gradual,
Is it CONSTANT or FREQUENT?

- **Started** with: Increased Activities, Bending, Long Drive, Fall, Illness, Lifting, Moving Furniture, Vehicle Accident, Occupational Injury, Sleeping, Sports, _____
- Injury Date _____
- Worse with: Bending, Coughing, Driving, Lifting, On Feet, Physical Activity, Sitting, Standing, Walking
- Gets Better With: On Feet, Physical Activity, Resting, Sitting, Standing, Walking, _____

What is the Context of your Complaint?:

- Your Work Status: Not improved enough to return to work, Returned to work but couldn't continue
- Did you have an X-ray? Was told X-ray was: Normal/Abnormal

Are there any MODIFYING FACTORS to your Complaint?: Any Current/Previous Treatment?
Acupuncture, Cold Pack, Chiropractic, Massage, Medical, Physical Therapy, _____
What is your **GOAL FOR TREATMENT**? i.e. Be able to do a Specific Task? Pain Free? _____
If this is a long term problem; why are you treating now?_____

PAST HEALTH HISTORY

Patient's Name: _____ DOB: _____ Date: _____

All information will be kept strictly confidential. Your responses will help determine if chiropractic, acupuncture or massage will benefit you. Unless we sincerely feel that your condition will respond satisfactorily, we will not recommend treatment.

Please answer for any of the following conditions you* Currently *have* or Have *had.

FAMILY HEALTH HISTORY	Age	Health Issues
Father		
Mother		
Sibling		
Grandparents		

SOCIAL HISTORY (PLEASE CIRCLE ANSWERS THAT APPLY)

EXERCISE: None / Aerobic / Avoids due to Pain / Frequent / Infrequent / Limited / Occasional / Regular

HISTORY GIVEN BY: Care Giver / Child / Guardian / Parent / Self / Spouse / Translator

MEDICAL CARE: Dental Exam (date): Eye Exam (date): Physical (date): / Never had one

WORK ENVIRONMENT: No problems/Stressful/Constant sitting/Constant Standing/Heavy Data Entry/Lifting

SMOKING STATUS: Smokes everyday/ some days/ Former Smoker/ Never a Smoker/ Unknown

SUBSTANCE USE: Alcohol: Caffeine Opiates: Codeine, Demerol, Hydrocodone, Morphine

IMMUNIZATION / VACCINATIONS: Influenza Date_____ Pneumonia Date_____

DRUG ALLERGIES? (List)			
CURRENT MEDICATION NAME	For What Symptom?	How Many Times a Day?	Strength?

REVIEW OF SYSTEMS PLEASE CIRCLE any items that CURRENTLY PERTAIN TO YOU:

MUSCULOSKELETAL: **General**: Numbness. -**Disability**: Able/Unable to work. -**Kidney/UTI problems. Muscles:** Ache, Atrophy, Wasting, Weakness. –**Posture is Abnormal. –Skeletal System:** Arthritis, Artificial Joints, Gout, Joint Pain, Osteoarthritis, Psoritaic or Rheumatoid Arthritis. –**Spine Problems:** Back Injury history, Back Surgery Date___, Neck Injury. -**Trauma or Recent Injury**.

NEUROLOGIC: Problems with: Incontinence, Dysphasia, Hearing, Neck limitation of motion, Orofacial paresthesia, Smell, Speech Swallowing Taste, Visual. Dizziness, Headaches, Trauma to head, Vertigo.

INTEGUMENTARY: Bruising, Dry skin, Itching, Lumps, Skin Cancer, Staph infection.

CARDIOVASCULAR: Cardiac history, Chest Pain, Hypertension, Murmur, Palpitations

CONSTITUTIONAL: Fatigue, Fever, Chronic Fatigue, Malaise, Muscle aches, Weight change.

HEMATOLOGIC / LYMPHATIC: Anemia, Bleeding skin, Hepatitis, HIV, Lymph Node, Lymphatic Malignancy: Hodgkins-Leukemia Acute Lymphocytic- Leukemia Acute Myelogeneous- Leukemia Chronic Lymphocytic- Non Hodgkin's Lymphoma.

Please check any of the following conditions you Currently have or Have had.

Does not apply (Y / N)

Auto Injury (Y / N) Date

ILLNESSES DATE

SIGNS & SYMPTOMS
- o Abdominal; Pain
- o Cough
- o Dizziness
- o Headache
- o Insomnia
- o Malaise (Fatigue)

ARTERIAL
- o Atherosclerosis
- o Peripheral Vascular Disease
- o Other: _____
- o Aortic or Abdominal Aneurysms

HEART DISEASE
- o Congestive Heart Failure
- o Hypertension
- o Other: _____

CEREBROVASCULAR
- o Aneurysms_____
- o Carotid Artery Disease
- o Stroke
- o Other: _____

CONGENITAL ANOMALIES

_____

CONNECTIVE TISSUE
- o Arthritis Juvenile Rheumatoid, Psoriatic, Rheumatoid
- o Lupus
- o Osteoarthritis

ENDOCRINE
- o Diabetes Type I / II
- o Gout
- o Hyperthyroidism (Graves disease)
- o Hypothyroidism

EAR/MOUTH/NOSE/THROAT
- o Menieres
- o Tinnitus (Ringing)
- o TMJ
- o Other:_____

EYE: Other: _____

GASTROINTESTINAL
- o Colon
- o Hernia
- o Liver / Gall Bladder
- o Pancreas
- o Stomach
- o (Chrons /Diverticulitis / IBS)
- o Other:_____

GENITOURINARY
- o Other: _____

HEMATOLOGY
- o Coagulation Defect
- o Other: _____

INFECTIOUS DISEASE

_____

SKIN/INTEGUMENT
- o Skin Cancer
- o Other:_____

LUNG (Respiratory)
- o Asthma
- o Emphysema
- o Other:_____

MUSCULOSKELETAL
- o Frozen Shoulder (Adhesive Capsulitis)
- o Ankylosing Spondylitis
- o Back Pain
- o Bursitis: Where_____
- o Dislocation
- o Epicondylitis
- o Fracture: What_____
- o Herniated disc
- o Muscle spasm
- o Osteochondritis Dessicans
- o Osteoporosis
- o Plantar Fascitis
- o Radicular Neuropathy
- o Rotator Cuff Syndrome
- o Sciatica
- o Scoliosis
- o Spinal Stenosis
- o Spondylolithesis
- o Tendonitis: Where_____
- o Torticollis

NEOPLASM'S
- o Cancer/Chemotherapy/ Radiation

NEUROLOGY
- o Bell's Palsy
- o Carpal Tunnel
- o Headache – Cluster –
  - o Migraine
- o Parkinson's
- o Other:_____

PSYCHIATRY
- o Attention Deficit Disorder
- o Depression
- o Drug dependency
- o Manic Depressive
- o Other_____

INJURIES DATE
- o Back Injury
- o Falls/Fracture (What)
- o Head Injury Joint Injury
- o Motor Vehicle Accident (When)
- o Soft Tissue Injury

SURGERIES DATE
- o None
- o Breast
- o Cardiovascular
- o Gastrointestinal
- o Musculoskeletal
- o Carpal Tunnel L/R
- o Spinal (Neck/Back)
- o Shoulder L/R
- o Knee L/R
- o Hip L/R
- o Other _____

TREATMENTS DATE
- o **Chiropractic Doctor:**_____
- o **Physical Therapy:**_____

PREVENTITIVE
- o **Mammogram Performed? Y/N Date:** _____
- o **Bone Density Date:** _____
- o **Colonoscopy Date:** _____

OB/GYN
- o **Pregnant? Y / N**
- o **DUE DATE:**_____

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: 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 as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

(Date)

OFFICE SIGNATURE **X**

ALSO **SIGN** THE **INFORMED CONSENT** ON **REVERSE** SIDE

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE X

(Or Patient Representative) (Indicate relationship if signing for patient)

ALSO **SIGN** THE **ARBITRATION AGREEMENT** ON **REVERSE** SIDE

Back & Neck Care Chiropractic, Acupuncture & Massage
Michael Pettet, DC, Jeff Melin, DC

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____
Signature of Patient of Representative Date

_____
Printed Name

11516 SE Mill Plain Blvd, 2C
Vancouver, WA 98684
P: 360.253.6674
F:360.253.8670
pettetchiro.com

Back & Neck Care Chiropractic Financial Policies

Michael Pettet, DC Jeffrey Melin, DC 11516 SE Mill Plain Blvd, Ste 2C, Vancouver, WA 98684 P: 360-253-6674 F: 360-253-8670
www.pettetchiro.com

Insurance Coverage:

Welcome to ***Back & Neck Care Chiropractic, Acupuncture, & Sports Massage.*** Your insurance policy is an agreement between you and your insurer, not between your insurer and this clinic. Like all types of care, coverage for chiropractic, acupuncture and massage services varies from insurer to insurer, and plan to plan. Most insurance policies require the beneficiary to pay a co-insurance, co-payment, and/or deductible. Our clinic will call your insurer to verify your benefits; however, we are not responsible for your insurer's final payment and benefit determinations. If we are unable to verify your insurance, you are responsible for our first visit fee, until your portion is verified. After insurance verification, if we have overestimated your responsibility, you will have a credit on file; if we have underestimated your portion, the first visit fee helps you avoid being behind on your account, or receiving a surprise bill in the mail.

Payments:

In order to help you determine your responsibility toward payment for services, please read the following, and initial your preference for the method of payment of your account. Please notify the office immediately if the status of your insurance has changed. First visit charges are expected to be paid prior to your first visit. We accept cash, check or credit card.

____**Option 1: Time of Service**—As I have no insurance, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered.

____**Option 2: Health Insurance**—I would like this clinic to bill my health insurance. I understand I am ultimately responsible for all costs of treatment. Additionally, not all services are covered by insurance. We will make every attempt to inform you of non-covered services so that you can make an informed decision; however, you are still responsible for paying for all services rendered.

____**Option 3: Worker's Compensation**—I would like this clinic to bill the Department of Labor & Industries (L&I)/or another responsible party. I understand I am responsible for reporting my accident to my employer, and for providing our office with the necessary insurance information, and completed Accident Report for L&I. Until this aforementioned information is provided, OR if the claim is denied I am required to pay for my care out of pocket. Approved Worker's Compensation claims are not required to pay for care as it is rendered. Transfer of Care claims will be verified with the claims manger. Reopening of claims closed past 90 days will require me to make personal arrangements for payment, and will be reimbursed if claim is allowed.

___**Option 4: Personal Injury**—I would like this clinic to bill my auto insurance, third party auto insurance, or personal injury claim. I understand I need to provide our office with the accident report, auto insurance, health insurance, and attorney, if applicable. If the claim is a possible third party liability, I am responsible for providing the other parties' insurance carrier information, as well as retaining an attorney Letter of Protection, in order to be seen in our office. Until necessary insurance information is gathered and verified for chiropractic care, you will be required to pay for your care on a cash basis. Patients with approved personal injury claims are not required to pay for care as it is rendered.

Missed Visit Policy:

It is the policy of ***Back & Neck Care Chiropractic, Acupuncture, & Sports Massage*** to assess a $30 missed visit fee to patients who cancel massage and acupuncture appointments with less than 24 hour notice. One missed visit will not result in the assessment of the fee, but you will be charged for any additional missed visits. This clinic provides care for many individuals and missed visits result in time lost that could have been used to provide care for others.

___My initials here indicate that I have read and understand the Missed Visit Policy.

*Notice: If your account becomes **PAST DUE**, and we have had no contact with you in over 90 days, your account will be sent to our collection agency. Every effort will be made to work with you to avoid this.*

I understand and agree to the Financial Policies of *Back & Neck Care Chiropractic, Acupuncture & Sports Massage*

Signature of Patient or Representative:_____ **Date:**_____

8/15/16

Back & Neck Care Chiropractic, Acupuncture & Sports Massage

11516 SE Mill Plain Blvd. #2C
Vancouver, WA 98684
Phone: (360) 253-6674
Fax: (360) 253-8670

Assignment of Patient Rights & Benefits

Name: _____ Claim or Member ID/Group Number: _____

I hereby instruct and direct _____ Insurance Company to pay by check made out
(Name of Insurance Company to be billed)
and mailed to:

Back & Neck Care Chiropractic
11516 SE Mill Plain Blvd, Ste 2C
Vancouver, WA 98684

Or

If my current policy prohibits direct payment to the doctor, I hereby also instruct and direct you to make out the check to me as follows: _____.
(Full Legal Name)

For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at _____ this _____ day of _____, 20_____

_____ _____
Signature of Policyholder Witness
Signature of Claimant, if other than Policyholder