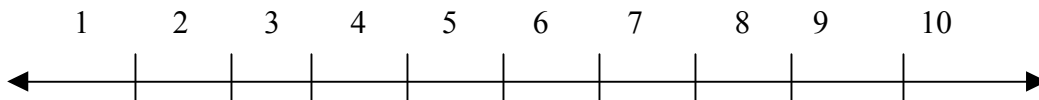


Chiropractic Headache Questionnaire

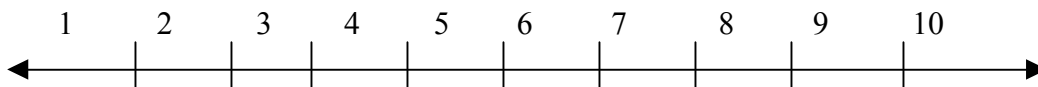
Patient's Name: _____ **Date:** _____

1. Did your headaches start after an accident, illness or infection? YES NO
2. When did your headaches first start?
3. Do you have more than one type of headache? YES NO
If Yes, please explain

4. How many regular headaches do you have per month?
5. How many migraine headaches do you experience per month?
6. How painful are your regular headaches? (Circle one number)



7. How painful are your migraine headaches? (Circle one number)



8. Are your headaches: constant come and go
9. Where are your headaches usually located? (Check all that apply)

Behind right eye	behind left eye	behind both eyes
Right temple	left temple	both temples
Top of head	neck	above both eyebrows
Back of head on right	back of head on left	back of head on both sides

10. What does the pain feel like?
____ Throbbing or pounding _____ Exploding ____ Sharp
____ Tightness (like a rubber band wrapped around the head)
____ Dull _____ Aching _____ Pressure

Please describe the pain in your own words:

11. Is your current headache today the worst you have ever experienced? YES NO
12. What % of your waking time do you have some degree of headache?
13. How often do the headaches occur? (daily, weekly, monthly, etc.)
14. Do the headaches occur at a certain time of the day?
morning afternoon night anytime all the time
15. Are the headaches becoming stronger, lasting longer or occurring more frequently?
YES NO
16. Do the headaches wake you up from sleeping? Never Occasionally Often
17. Does rest or sleep relieve the headache? YES NO
18. Do the headaches stop you from doing things (like playing, watching TV, going outside) ?
YES NO
Which activities are restricted?
19. Have you missed school or work because of a headache? Yes No
20. Do any of the following occur before or during your migraine headaches?
(Circle all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Increased appetite |
| <input type="checkbox"/> Bothered by light/noise | <input type="checkbox"/> Blurred/double vision | <input type="checkbox"/> Sparkling, flashing, or colored lights |
| <input type="checkbox"/> Tired or sleepy | <input type="checkbox"/> Eyelid droops | <input type="checkbox"/> Loss of vision |
| <input type="checkbox"/> Feeling lightheaded | <input type="checkbox"/> Numbness / tingling | <input type="checkbox"/> Weakness of arm or leg |
| <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Speech difficulty | <input type="checkbox"/> Loss of consciousness |
| <input type="checkbox"/> Runny nose | <input type="checkbox"/> Stomachache | <input type="checkbox"/> Other _____ |

21. Do any of the following bring on your migraine headaches or make them worse?
(Check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Stress (worry, anger) | <input type="checkbox"/> Bright lights | <input type="checkbox"/> Weather Change |
| <input type="checkbox"/> "Letdown" after stress | <input type="checkbox"/> Loud noise | <input type="checkbox"/> Heavy lifting |
| <input type="checkbox"/> Air travel | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Certain smells, odors |
| <input type="checkbox"/> Missed meals | <input type="checkbox"/> Sexual activity | <input type="checkbox"/> Coughing, straining, bending over |
| <input type="checkbox"/> Certain foods (chocolate, cheese, MSG, milk) | <input type="checkbox"/> Medications: | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Allergies | <input type="checkbox"/> Other: _____ |

22. Do any of the following make your headaches better? (Check all that apply)

- | | | |
|---|---------------------------------------|---|
| <input type="checkbox"/> Rest | <input type="checkbox"/> Exercise | <input type="checkbox"/> Quiet and darkness |
| <input type="checkbox"/> Hot or cold compress | <input type="checkbox"/> Massage | <input type="checkbox"/> Warm shower |
| <input type="checkbox"/> Pressure over migraine | <input type="checkbox"/> Other: _____ | |

Medications: _____

23. If you are female, do your headaches change with the following?
(Check all that apply)

- Menstrual Periods Birth Control Pills Pregnancy Other Hormonal Drugs

24. Do any of your family members have headaches?

- Yes No If "yes", explain (who): _____

25. Have you ever had a head or a neck injury requiring medical treatment?

- Yes No If "yes", describe: _____

26. Have you ever been diagnosed to have any health disorder (e.g. high blood pressure, asthma, heart disease, gastric ulcers, others)?

- Yes No If "yes", please list: _____

27. Have you had your headaches evaluated by a neurologist?

- Yes No If "yes", when, where and by whom? _____

What was the diagnosis? (Check all that apply.)

- Migraine Tension Type Cluster

28. What tests were done?

- | | | |
|-------------------------------------|--|--|
| <input type="checkbox"/> CT scan | <input type="checkbox"/> Eye Exam | <input type="checkbox"/> Sinus X-rays |
| <input type="checkbox"/> MRI | <input type="checkbox"/> Dental Exam | <input type="checkbox"/> Allergy Tests |
| <input type="checkbox"/> Spinal Tap | <input type="checkbox"/> Blood tests (etc) | |

Any other tests? _____

29. What prescription medications are you taking for your headaches?

30. What over the counter medications are you currently taking regularly for your headaches?

31. Please list all other medications that you are taking for any health problem.
32. What other forms of treatment have you tried for your headaches?
 (Circle all that apply):
 Chiropractic Massage Herbs Acupuncture Meditation/Yoga Other: _____
33. On a scale of 1-10, rate your stress level over the last 6 months _____
 Describe any major stresses in the last year
34. On average, how many 8 ounce servings daily do you have of the following:
- | | | |
|-----------------------------------|------------------------------|-----------------|
| _____ Water | _____ Coffee | _____ Tea |
| _____ Other Caffeinated Beverages | _____ Soda | _____ Diet Soda |
| _____ Beer or Wine | _____ Other Alcoholic Drinks | |
35. Do you regularly eat breakfast? Yes No
36. How often do you eat during the day? _____
37. How many hours of sleep do you get a night? _____ hours
38. Do you: (mark all that apply)
- _____ usually sleep through the night without waking
 - _____ wake up frequently through the night
 - _____ wake up and can't go back to sleep
 - _____ wake feeling rested
 - _____ wake feeling tired
39. Please describe what you regularly do for exercise, how frequently and for how long.
40. What questions do you have about your headaches? What worries you most?

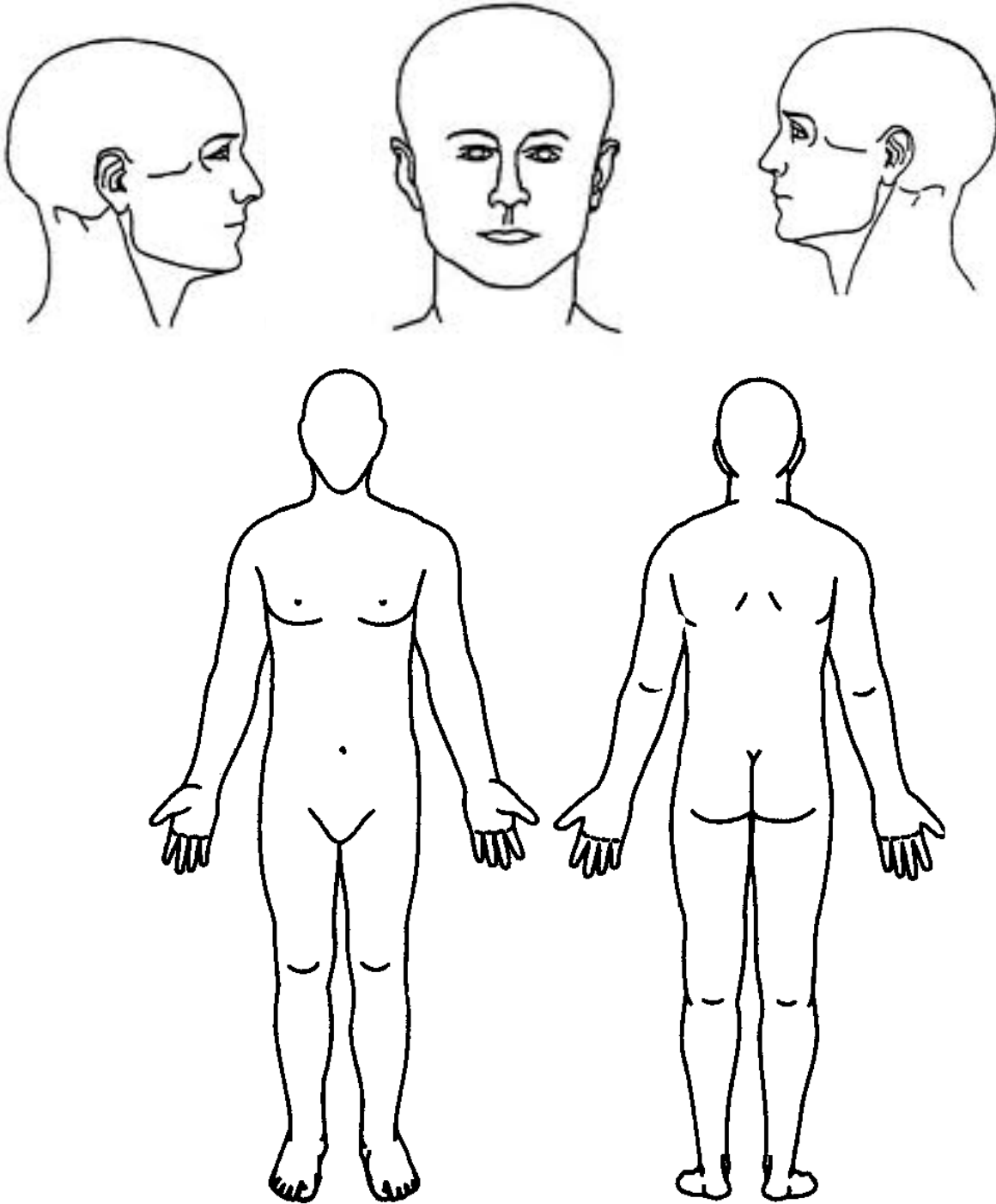
How are you feeling currently?

Please complete this drawing carefully. Mark on the drawing the areas where you feel the described sensation. Use the appropriate symbols and include all involved areas of your body.

NUMBNESS ===
BURNING PAIN xxx

PINS & NEEDLES OOO
STABBING PAIN |||

ACHING PAIN !!!



Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name: _____ Last Name: _____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ Gender (Circle one): Male / Female Preferred Language: _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight: _____ Blood Pressure: _____ / _____

Informed Consent

Before beginning treatment, it is our office policy to inform you of what to expect, possible complications of chiropractic, as well as complications of other forms of treatment. Remember that all forms of treatment (including non-treatment!) have associated risks. **If you have any questions, please be sure to ask the doctor.**

What to expect

The treatment at our office will consist of manipulation of the joints and soft tissues, using the hands and/or a mechanical instrument. You may feel movement, and you may hear joint clicks or other noises. Physical therapy methods, including therapeutic exercise, massage and heat or ice may also be used.

Chiropractic risks

Chiropractic treatment is one of the safest methods of treating spinal problems. Still, unexpected problems can occur. Minor, temporary problems, such as soreness and stiffness can occur, especially in the beginning of a treatment plan. More significant problems, such as fracture of a weakened bone or sprain/disc injuries are rare. A stroke following neck manipulation is an extremely rare complication, occurring less than 1 per million treatments. Stroke has also been the result of ordinary activities, such as head turning or stargazing.

Other treatments and risks

There are other treatments used by medical doctors. Their risks include:

Medications: Many commonly used medications, such as NSAIDs (e.g., Advil, Aleve or Tylenol), carry risks of tissue damage, including stomach ulcers or kidney damage. This damage can occur quickly, and may irreversible. There is a significantly higher risk of developing a serious complication with NSAIDs as opposed to chiropractic. Other medications are habit forming, and may mask pain to allow further tissue damage.

Surgery: Surgery is the treatment of choice in less than 1% of back pain patients. Your doctor has screened for surgical “red flags”, and will refer you for a surgical opinion if indicated. Clinical results of surgery for mechanical back pain have been disappointing, and exposes you to unnecessary hospital and medication risk.

Rest/non-treatment: Bedrest has been shown to increase the likelihood of re-occurrence of back episodes, and make chronic pain more likely. Likewise, non-treatment may cause a permanent mechanical problem to develop, causing future back problems.

I have read the above, and give my consent to begin chiropractic treatment.

Printed Name: _____

Date: _____

Signature: _____

Steve Shirley, D.C. W. Jack Choate, D.C. Brittany Rush, D.C.

Spinal & Sports Care Clinic, P.S. 12905 E. Sprague Ave., Spokane Valley, WA 99216 (509) 922-0303 Fax (509)922-0657

Spinal & Sports Care Clinic, PS
12905 E Sprague Ave., Spokane Valley, WA 99216

First Name (Legal): _____ (MI): _____ Last Name: _____

Social Security Number: ____/____/____ Birth Date: ____/____/____ Married Single Other

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Number: _____ Cell Number: _____ Work Number: _____

May we leave a message if we need to? Yes No E-mail address: _____

Occupation: _____ Patient Employer/School: _____

Who may we thank for referring you? _____

In Case of Emergency Contact

Name: _____ Relationship to patient: _____

Phone Number: _____ Work Number: _____

Insurance Information

Who is responsible for this account?: _____ Relationship to patient: _____

Primary Insurance Company: _____ Phone Number: _____

Subscriber Name: _____ Subscriber Date of Birth: ____/____/____

Insurance ID: _____ Group Number: _____

Employer: _____ Work Number: _____

Secondary Insurance Company: _____ Phone Number: _____

Subscriber Name: _____ Subscriber Date of Birth: ____/____/____

Insurance ID: _____ Group Number: _____

Employer: _____ Work Number: _____

I understand it is my responsibility to provide Spinal & Sports Care Clinic with accurate information concerning my insurance coverage and personal information. I understand that all quotes are an estimate and all balances are subject to the information Spinal and Sports Care Clinic received from my insurance carrier. I understand there are no guarantees of benefits and I am financially responsible for all charges rendered whether or not paid by my insurance. I authorize Spinal & Sports Care Clinic the use of my signature on all insurance submissions. I also authorize Spinal & Sports Care Clinic to provide information to my insurance carrier(s) and their agents for the purpose of obtaining payment for services rendered and assign directly to Spinal & Sports Care Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand Spinal & Sports Care Clinic will not become involved in any dispute between me and my insurance company. It will be my responsibility to settle any such dispute.

Print Patient Name

Date

Signature of patient/parent/guardian/personal representative

Relationship to Patient

Spinal & Sports Care Clinic, PS
12905 E Sprague Ave, Spokane Valley, WA 99216
Phone (509) 922-0303 / Fax (509) 922-0657

HIPAA NOTICE OF PRIVACY PRACTICES

PLEASE REVIEW THIS NOTICE CAREFULLY. IT DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU MAY GAIN ACCESS TO THAT INFORMATION.

POLICY STATEMENT

This Practice is committed to maintaining the privacy of your protected health information (“PHI”), which includes information about your medical condition and the care and treatment you receive from the Practice and other health care providers. This Notice details how your PHI may be used and disclosed to third parties for purposes of your care, payment for your care, health care operations of the Practice, and for other purposes permitted or required by law. This Notice also details your rights regarding your PHI.

USE OR DISCLOSURE OF PHI

The Practice may use and/or disclose your PHI for purposes related to your care, payment for your care, and health care operations of the Practice. The following are examples of the types of uses and/or disclosures of your PHI that may occur. These examples are not meant to include all possible types of use and/or disclosure.

- Care – In order to provide care to you, the Practice will provide your PHI to those health care professionals directly involved in your care so they may understand your medical condition and needs and provide advice or treatment. For example, your physician may need to know how your condition is responding to the treatment provided by the Practice.
- Payment – In order to get paid for some or all of the health care provided by the Practice, the Practice may provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, the Practice may need to provide your health insurance carrier with information about health care services you received from the Practice so the Practice may be properly reimbursed.
- Health Care Operations – In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice’s personnel in providing care to you.

Note: Genetic information is protected by law and is not considered part of Health Care Operations.

- Fundraising – To the extent that the Practice engages in fundraising activities (i.e. appeals for money, help, or event sponsorships), certain types of PHI may be disclosed for these purposes, unless you specifically ‘opt out’ of receiving notification. To ‘opt out’, call or email the Practice to be excluded from fundraising campaigns.

AUTHORIZATION NOT REQUIRED

The Practice may use and/or disclose your PHI, without a written Authorization from you, in the following instances:

1. De-identified Information – Your PHI is altered so that it does not identify you and, even without your name, cannot be used to identify you.
2. Business Associate – To a business associate, who is someone the Practice contracts with to provide a service necessary for your treatment, payment for your treatment and/or health care operations (e.g., billing service or transcription service). The Practice will obtain satisfactory written assurance, in accordance with applicable law, that the business associate and their subcontractors will appropriately safeguard your PHI.
3. Personal Representative – To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.
4. Public Health Activities – Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease, injury or disability. This includes reports of child abuse or neglect.
5. Federal Drug Administration – If required by the Food and Drug Administration to report adverse events, product defects, problems, biological product deviations, or to track products, enable product recalls, repairs or replacements, or to conduct post marketing surveillance.
6. Abuse, Neglect or Domestic Violence – To a government authority, if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes the disclosure is necessary to prevent serious harm or if the Practice believes you have been the victim of abuse, neglect or domestic violence. Any such disclosure will be made in accordance with the requirements of law, which may also involve notice to you of the disclosure.
7. Health Oversight Activities – Such activities, which must be required by law, involve government agencies involved in oversight activities that relate to the health care system, government benefit programs, government regulatory programs and civil rights law. Those activities include, for example, criminal investigations, audits, disciplinary actions, or general oversight activities relating to the community's health care system.
8. Family and Friends - Unless expressly prohibited by you, the Practice may disclose PHI to a member of your family, a relative, a close friend or any other person you identify, as it *directly* relates to that person's involvement in your health care. If you do not express an objection or are unable to object to such a disclosure, we may disclose such information, as necessary, if we determine that it is in your best interest based on our professional judgment.
9. Judicial and Administrative Proceeding – For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.
10. Law Enforcement Purposes – In certain instances, your PHI may have to be disclosed to a law enforcement official for law enforcement purposes. Law enforcement purposes include: (1) complying with a legal process (i.e., subpoena) or as required by law; (2) information for identification and location purposes (e.g., suspect or missing person); (3) information regarding a person who is or is suspected to be a crime victim; (4) in situations where the death of an individual may have resulted from criminal conduct; (5) in the event of a crime occurring on the premises of the Practice; and (6) a medical emergency (not on the Practice's premises) has occurred, and it appears that a crime has occurred.
11. Coroner or Medical Examiner – The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death, or to a funeral director as permitted by law and as necessary to carry out its duties.
12. Organ, Eye or Tissue Donation – If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.

13. Research – If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI such as approval of the research by an institutional review board, the de-identification of your PHI before it is used, and the requirement that protocols must be followed. Individuals have the option to ‘opt out’ of certain types of research activities.
14. Avert a Threat to Health or Safety – The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.
15. Specialized Government Functions – When the appropriate conditions apply, the Practice may use PHI of individuals who are Armed Forces personnel: (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veteran Affairs of eligibility for benefits; or (3) to a foreign military authority if you are a member of that foreign military service. The Practice may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities including the provision of protective services to the President or others legally authorized.
16. Inmates – The Practice may disclose your PHI to a correctional institution or a law enforcement official if you are an inmate of that correctional facility and your PHI is necessary to provide care and treatment to you or is necessary for the health and safety of other individuals or inmates.
17. Workers’ Compensation – If you are involved in a Workers’ Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers’ Compensation system.
18. Disaster Relief Efforts – The Practice may use or disclose your PHI to a public or private entity authorized to assist in disaster relief efforts.
19. Marketing - Face to face communication directly with the patient, treatment and coordination of care activities, refill reminders or communications about drugs that have already been prescribed, or promotional gifts of nominal value do not require authorization as long as the Practice receives no financial remuneration for making the communication. All other situations require separate authorization.
20. Required by Law – If otherwise required by law, but such use or disclosure will be made in compliance with the law and limited to the requirements of the law.

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your *written* Authorization. These authorizations may be revoked at any time, however, we cannot take back disclosures already made with your permission.

We also will NOT use or disclose your PHI for the following purposes, where applicable, without your express *written* Authorization:

- Marketing - This does not including marketing communications described in item #19. The Practice will obtain prior authorization before disclosing PHI in connection with marketing activities in which financial remuneration is received.
- Sales - The Practice may receive payment for sharing your information in specific situations (i.e. public health purposes or specific research projects - see #12 above).
- Specially protected information - Certain types of information such as psychotherapy notes, HIV status, substance abuse, mental health, and genetic testing information require their separate written authorization for the purposes of treatment, payment or healthcare operations.

APPOINTMENT REMINDER

The Practice may, from time to time, contact you to provide appointment reminders. The reminder may be in the form of a letter or postcard. The Practice will try to minimize the amount of information contained in the reminder. The Practice may also contact you by phone and, if you are not available, the Practice will leave a message for you.

TREATMENT ALTERNATIVES/BENEFITS

The Practice may, from time to time, contact you about treatment alternatives it offers, or other health benefits or services that may be of interest to you.

YOUR RIGHTS

You have the right to:

- Revoke any Authorization, in writing, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer. Marketing revocations may be submitted to the Practice via telephone or email.
- Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.
- Restrict disclosures to your health plan when you have paid out-of-pocket in full for health care items or services provided by the Practice.
- Receive confidential communications of PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.
- Inspect and copy your PHI as provided by law. To inspect and copy your PHI, you must submit a written request to the Practice's Privacy Officer. In certain situations that are defined by law, the Practice may deny your request, but you will have the right to have the denial reviewed. The Practice may charge you a fee (to cover costs incurred by the Practice to reproduce records) for the cost of copying, mailing or other supplies associated with your request.
- Amend your PHI as provided by law. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the originating individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you have the right to submit a written statement of disagreement.
- Receive an accounting of non-routine disclosures of your PHI as provided by law. To request an accounting, you must submit a written request to the Practice's Privacy Officer. The request must state a time period which may not be longer than six years and may not include the dates before April 14, 2003. The request should indicate in what form you want the list (such as a paper or electronic copy). The first list you request within a 12 month period will be free, but the Practice may charge you for the cost of providing additional lists in that same 12 month period. The Practice will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.

- Receive a paper copy of this Notice of Privacy Practices from the Practice upon request.
- To file a complaint with the Practice, please contact the Practice's Privacy Officer. All complaints must be in writing. If your complaint is not satisfactorily resolved, you may file a complaint with the Secretary of Health and Human Services, Office for Civil Rights. Our Privacy Officer will furnish you with the address upon request.
- To obtain more information, or have your questions about your rights answered, please contact the Practice's Privacy Officer, Kelli Jessen.

PRACTICE'S REQUIREMENTS

The health care office:

- Is required by law to maintain the privacy of your PHI and to provide you with this Notice of Privacy Practices upon request.
- Is required to abide by the terms of this Notice of Privacy Practices.
- Reserves the right to change the terms of this Notice of Privacy Practices and to make the new Notice of Privacy Practices provisions effective for all of your PHI that it maintains.
- Will not retaliate against you for making a complaint.
- Must make a good faith effort to obtain from you an Acknowledgment of receipt of this Notice.
- Will post this Notice of Privacy Practices in its lobby and on the Practice's web site, if the Practice maintains a Web site.
- Will inform you in a timely manner, if there is a case of a breach of unsecured health information.

PATIENT AUTHORIZATION FOR RELEASE OF PHI

Patient Name _____ Date of Birth: _____

Address _____

Phone Number _____ Chart Number _____

I request and authorize Spinal and Sports Care Clinic PS to use and/or disclose my:

- Protected Health Information (PHI):** PHI means information about a patient, including demographic information that may identify a patient, that relates to the patient's past, present or future physical or mental health or condition, related health care services or payment for health care services
- Sensitive Protected Health Information (SPHI):** SPHI means Protected Health Information that pertains to particularly sensitive information, as defined by state law, such as (i) an individual's HIV status or treatment of an individual for an HIV-related illness or AIDS, or (ii) an individual's substance abuse condition or treatment of an individual for mental illness.

I authorize disclosure of the following information from my medical record:

Note: Include a detailed description of information to be released including dates.

Release records to:

Name: _____ Telephone: _____

Address _____

Purpose(s) for the release:

Note: If the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose.

I Understand that:

- Treatment will not be conditional on whether I sign this Authorization.
- This Authorization is voluntary and that I have the right to refuse to sign it.
- If I sign this authorization, I may revoke it later by sending a written notice of revocation to the privacy office at the practice.

Note: The only exception to your right to revoke is if the practice has already acted in reliance upon the authorization.

- This authorization will expire on ____/____/____ OR when the following event occurs:
- The information disclosed pursuant to this Authorization, except information protected by Federal and/or State regulations about confidentiality of drug and alcohol abuse records, HIV and Mental Health, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws.
- This authorization CANNOT be used to disclose Psychotherapy Notes.
- Once signed, the Practice will provide me with a copy of this Authorization.
- I understand that the Practice will provide me with a copy of this Authorization once signed by me.

Spinal and Sports Care, PS
12905 E Sprague Ave, Spokane Valley, WA 99216
Phone (509) 922-0303 / Fax (509) 922-0365

Signature(s)

Patient signature _____ Date _____

Sign below if you are a personal representative of the patient.

Representative signature _____ Date _____

Print Name _____

Relationship to Patient _____

FOR OFFICE USE ONLY

Verification method:

Date

Verification by:

Financial Policy

Payment Methods

We accept cash, checks, Visa, Master Card, American Express, Discover and debit cards.

Self Pay

If you have no insurance or insurance that has no chiropractic benefits, payment at the time of service will be expected, unless prior arrangements have been made. We offer at time of service discount for payment in full on the day of service.

Insurance

We are contracted with most insurance companies. However, some insurance companies arbitrarily select certain services that they will not cover and/or must be medically necessary. It is your responsibility to understand the scope and limitations of your insurance policy and you are financially responsible for all charges rendered whether or not paid by your insurance. *At the time of service you are responsible for all co-pays, deductibles and any estimated fees for services not covered by your insurance plan.* As a courtesy we will bill your insurance company; however it is your responsibility to provide us with accurate information.

Examination & Re-examination

Should I have a new complaint or if it has been over 1 year since my last visit a new examination will be completed. If my insurance does not pay for this service it is my responsibility to pay in full at time of service unless prior arrangements have been made.

Motor Vehicle Accident

You will not be responsible for paying at time of service if you have a personal injury protection coverage plan we can bill for your care. If you've exhausted your personal injury protection coverage you will be financially responsible for all charges rendered whether or not paid by the insurance carrier.

Workman's Compensation/Self Insured/Federal

You will not be responsible for paying at time of service if you have an open L&I claim or filing for L&I. If your L&I claim has been denied or closed within the course of treatment you are financially responsible for all charges rendered whether or not paid by L&I.

NO Show Policy

You will be considered a no show if you miss an appointment and do not notify us at least four hours in advance. A \$40.00 charge will be applied to your account and must be paid prior to being seen by the provider at your next visit. If you miss two appointments in a row, any remaining appointments will be cancelled and you will not be able to schedule with the provider until all fees are paid. If you miss three appointments without canceling you may be discharged from care.

I have read and understand the above terms and I accept full responsibility for the services incurred with Spinal and Sports Care Clinic.

Print Name

Signature

Date

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

Patient

Signature

Date

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the Acknowledgment
- An emergency situation prevented us from obtaining Acknowledgment
- Other (Please Specify) _____

Staff signature

Date