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 $45.00 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

Revised 04/26/2012
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)
   
   1 2 3 4 5 6 7 8 9 10

7. How painful are your migraine headaches? (Circle one number)
   
   1 2 3 4 5 6 7 8 9 10

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:

Stevens Shirley, D.C.    W. Jack Choate, D.C.      Brittany Rush, D.C.   Kenneth Van Dyken, D.C.
12905 E. Sprague Ave., Spokane Valley, WA 99216   (509) 922-0303
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)

   - Nausea
   - Bothered by light/noise
   - Tired or sleepy
   - Feeling lightheaded
   - Difficulty concentrating
   - Runny nose
   - Vomiting
   - Blurred/double vision
   - Eyelid droops
   - Numbness / tingling
   - Speech difficulty
   - Stomachache
   - Increased appetite
   - Sparkling, flashing, or colored lights
   - Loss of vision
   - Weakness of arm or leg
   - Loss of consciousness
   - Other____________________

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

   - Stress (worry, anger)
   - “Letdown” after stress
   - Air travel
   - Missed meals
   - Certain foods (chocolate, cheese, MSG, milk)
   - Exercise
   - Bright lights
   - Loud noise
   - Fatigue
   - Sexual activity
   - Medications:
   - Allergies
   - Weather Change
   - Heavy lifting
   - Certain smells, odors
   - Coughing, straining, bending over
   - Alcohol
   - Other:___________________
22. Do any of the following make your headaches better? (Check all that apply)

- [ ] Rest
- [ ] Exercise
- [ ] Quiet and darkness
- [ ] Hot or cold compress
- [ ] Massage
- [ ] Warm shower
- [ ] Pressure over migraine
- [ ] 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?
   - [ ] CT scan
   - [ ] Eye Exam
   - [ ] Sinus X-rays
   - [ ] MRI
   - [ ] Dental Exam
   - [ ] Allergy Tests
   - [ ] Spinal Tap
   - [ ] 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 === PINS & NEEDLES OOO ACHING PAIN !!!
BURNING PAIN xxx STABBING PAIN |||
HIPPA AUTHORIZATION

By signing this form, I 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 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.*

• 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.

By signing this form below, I acknowledge that 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.

**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**

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 prevented us from obtaining Acknowledgment
- [ ] Other (Please Specify) ______________________________________________________

Staff signature_____________________________ Date________________________
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: ________________________________________
AUTHORIZATION FOR VERBAL COMMUNICATION

Patient Name: ______________________________________ Date of Birth: __________________________

By signing this form, I authorize Spinal and Sports Care Clinic PS to discuss health information, in person or by telephone, with the following family members or persons directly involved in my medical care.

NAME (please print): _____________________________________________________________________
PHONE NUMBER: _____________________________________________________________________
RELATIONSHIP: _____________________________________________________________________

NAME (please print): _____________________________________________________________________
PHONE NUMBER: _____________________________________________________________________
RELATIONSHIP: _____________________________________________________________________

I AUTHORIZATE THIS COMMUNICATION TO INCLUDE:
□ All health care information
□ Health care information relating to the following treatment/condition: __________________________
□ Health care information in my medical records for the date(s): __________________________
□ Other (i.e. x-rays, bills, etc) specify date/item(s): ________________________________________
□ Can schedule and reschedule appointments on my behalf

I UNDERSTAND THAT THIS AUTHORIZATION IS:
• Limited to verbal and telephone conversations and does not permit or authorize the release of any written health information to any of the individuals named above.
• Limited to the specific timeframe determined by me and that if I do not specify a specific timeframe, this authorization will remain in effect until it is revoked in writing.

I further understand that if I do not want verbal discussion to be permitted between my health care provider and the individual(s) named above, I have the right to revoke this authorization in writing at any time. I understand that this written revocation will not affect any disclosures of my medical information that the person and/or organization listed on this authorization that have already made, in reliance on this authorization before the time I revoke it.

This document has been explained to me and all my questions have been answered satisfactorily.

____________________________________________________________________________________  ________/______/___________
(Signature of patient or legal representative) (Date)

________________________  ______________________
(relationship to patient)

This authorization is NOT valid unless it is signed and date by the patient or their representative.
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: ___________________________

Military: □ Active □ Veteran □ N/A 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 ____________________________