CONFIDENTIAL HEALTH INFORMATION

Capitol Chiropractic and Family Wellness Center • Don Lathrop, D.C.
1728 State Ave NE • Olympia WA 98506 • (360) 352-2488
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Name_____ Date of birth _____ Gender_____

Address_____ City _____ State _____ Zip Code_____

Cell #_____ Home #_____ Email _____

May we send you text reminders for appointments? Yes □ No □ May we leave a voicemail? Yes □ No □

May we send you educational health care information via email? Yes □ No □

Have you consulted a chiropractor before? Yes [ ] No [ ] • Whom did you see? _____

Referred to this office by _____

Have you received a massage before? Yes [ ] No [ ] • Whom did you see? _____

Do you have a referral for massage? Yes [ ] No [ ] *If no, you must get one. Self-referral is not accepted.*

INSURANCE INFORMATION

Insurance card(s) on file ☐

Primary insurance _____ ID # _____ Group #_____

Secondary insurance _____ ID # _____ Group #_____

EMERGENCY CONTACT INFORMATION

Name_____ Primary Phone #_____ Relationship _____

Name_____ Primary Phone #_____ Relationship _____

MEDICAL HISTORY

Primary Care Provider_____ Injury as a result of: Auto [ ] Work [ ] Other [ ]

Have you seen a chiropractor before: Yes [ ] No [ ] If yes, when: _____

Have you seen a massage therapist before: Yes [ ] No [ ] If yes, when: _____

When did symptoms begin (date): _____ Have you had these before: Yes [ ] No [ ]

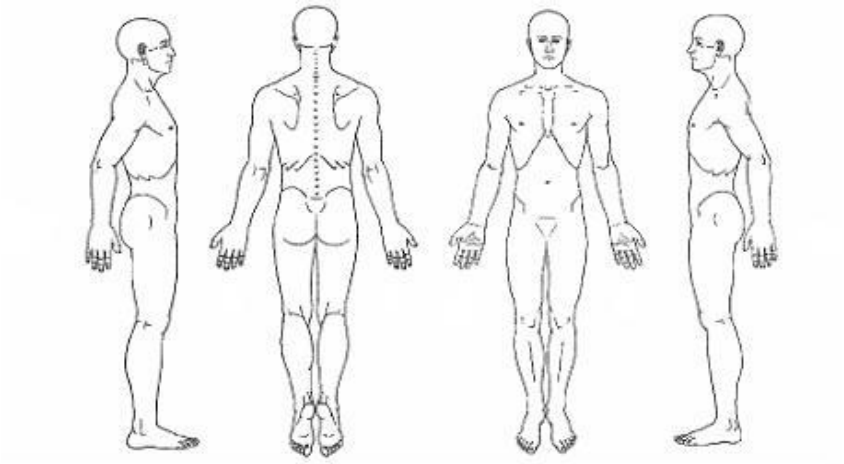
How often do you have pain: _____

Pain is interfering with (circle all that apply): Work Sleep Daily Routine Recreation Other

Activities difficult/painful to perform (circle all that apply):
Lying down Walking Twisting Sitting Bending

Location of Injury : "0" for current "x" for past

Numbness [ ]
Tingling [ ]
Stiffness [ ]
Dull [ ]
Aching [ ]
Cramps [ ]
Nagging [ ]
Sharp [ ]
Burning [ ]
Shooting [ ]
Throbbing [ ]
Stabbing [ ]



Pain Level: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Are you comfortable with your massage therapist working on your glutes? _____ (initial please)

Are you currently taking any medications? _____

_____

Past Surgeries/Injuries _____

_____

Does anything aggravate and or relieve your symptoms? _____

_____

Prior interventions for your injury: _____

_____

Current or Past Conditions
(circle all that apply):

Osteoporosis	Yes / No	High blood pressure	Yes / No	Blurred vision	Yes / No
Arthritis	Yes / No	Low blood pressure	Yes / No	Ringing in ears	Yes / No
Scoliosis	Yes / No	High cholesterol	Yes / No	Hearing loss	Yes / No
Neck pain	Yes / No	Poor circulation	Yes / No	Chronic ear infection	Yes / No
Back problems	Yes / No	Angina	Yes / No	Loss of smell	Yes / No
Hip disorders	Yes / No	Excessive bruising	Yes / No	Loss of taste	Yes / No
Knee pain	Yes / No	Asthma	Yes / No	Skin cancer	Yes / No
Foot/ankle pain	Yes / No	Apnea	Yes / No	Psoriasis	Yes / No
Shoulder problems	Yes / No	Emphysema	Yes / No	Eczema	Yes / No
Elbow/wrist pain	Yes / No	Hay fever	Yes / No	Acne	Yes / No
TMJ issues	Yes / No	Shortness of breath	Yes / No	Hair loss	Yes / No
Poor posture	Yes / No	Pneumonia	Yes / No	Rash	Yes / No
Anxiety	Yes / No	Anorexia/bulimia	Yes / No	Thyroid issues	Yes / No
Depression	Yes / No	Ulcer	Yes / No	Immune disorders	Yes / No
Headache	Yes / No	Food sensitivities	Yes / No	Hypoglycemia	Yes / No
Dizziness	Yes / No	Heartburn	Yes / No	Frequent infection	Yes / No
HIV/AIDS	Yes / No	Constipation	Yes / No	Swollen glands	Yes / No
Weakness	Yes / No	Diarrhea	Yes / No	Low energy	Yes / No
Kidney stones	Yes / No	Infertility	Yes / No	Bedwetting	Yes / No
Prostate issues	Yes / No	Erectile dysfunction	Yes / No	PMS symptoms	Yes / No
Fainting	Yes / No	Low libido	Yes / No	Poor appetite	Yes / No
Fatigue	Yes / No	Sudden weight loss/gain	Yes / No	Diabetes	Yes / No

Please read each statement carefully and sign in agreement:

- I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and release on my behalf for seeking reimbursement from any involved third parties.
- I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in this office.
- I acknowledge that any insurance I may have, is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.
- To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or the cause of my health concern.

Print name of Patient _____

Signature of Patient or Guardian _____ Date _____

FINANCIAL AGREEMENT
Capitol Chiropractic and Family Wellness Center

I agree that, in return for the services provided by the doctors and therapists at *Capitol Chiropractic and Family Wellness Center*, I will pay my account at the time of services are rendered or I will make financial arrangements satisfactory to *Capitol Chiropractic and Family Wellness Center* for payment. If my insurance company or health plan designates co-payments, co-insurance and/or deductibles, I agree to pay them to *Capitol Chiropractic and Family Wellness Center*.

No Insurance Coverage: payment is expected on the day services are rendered. We accept cash, check, or credit card.

Insurance Coverage: insurance is a contract between you and your insurance company. You will need to pay your co-payments at the time of service. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the **final determination** of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by them. It is the responsibility of the patient to verify with your insurance company if the provider(s) you are seeing are contracted with the insurance. **If your insurance company requires a referral and/or pre-authorization, it is your responsibility to obtain and provide that to our office.** Failure to obtain the referral and/or pre-authorization may result in a denial from the insurance company and the balance will be your responsibility.

Medicare: We are a participating provider with Medicare Part B. We agree to bill and accept contractual adjustments from Medicare. There may be services and supplies rendered in our office that are not covered by Medicare and therefore required an Advanced Beneficiary Notice (ABN) be signed by the patient/guarantor. By signing the ABN, it is understood that you are financially responsible for payment of any services and/or supplies that are not deemed medically necessary by Medicare.

Monthly Statement: If there is a patient balance on the account, we will send you a monthly statement. Patients are responsible for all charges resulting from treatment provided at *Capitol Chiropractic and Family Wellness Center*. Payment is due within 30 days of receipt of this statement unless other financial arrangements have been made with the office manager.

Past Due Accounts: I understand and agree that if my account is **delinquent past 90 days** without financial arrangement, I may be turned over to the collection agency used by *Capitol Chiropractic and Family Wellness Center*.

Returned Checks: there is a fee of $40.00 on any checks returned by the bank due to non-sufficient funds or otherwise.

Once you sign this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

_____	_____	_____
Print Name of Patient	Signature of Patient or Guardian	Date

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 CAREFUL

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 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, and employee review activities.

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, and law enforcement. 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 physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____	_____	_____
Print Name of Patient	Signature of Patient or Guardian	Date

INFORMED CONSENT FOR MASSAGE

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that the massage should not be construed as a substitute for medical examination, diagnosis, or treatment. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, proscribe, or treat any physical or mental illness and that nothing said in the source of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the massage therapist updated as to any changed in my medical profile during the session and understand there shall be no liability on the massage therapist' part should I fail to do so. I also understand that the License Massage Therapist reserves the right to refuse to perform massage on anyone who he/she/ deems to have a condition for which massage is contraindicated.

NO SHOW POLICY FOR MASSAGE

Thank you for choosing Capitol Chiropractic and Family Wellness as that provider of your therapeutic massage.

We appreciate that your time is valuable and trust that you recognize the value of our therapist time as well. In the event you are unable to attend a scheduled therapy session, we require that you notify our office 24 hours prior to the scheduled appointment.

If we do not receive this notification of cancellation, you will be assessed a **$45.00 NO SHOW FEE** and cannot be billed to the client's insurance. The **NO SHOW FEE** will be paid prior to receiving further massage services from our office. We do understand that life is filled with unexpected emergencies. In the case of an emergency, the **NO SHOW FEE** *may be* waived.

I have read the Consent to Treat and the Notification of No Show Fee Policy and understand my responsibility and concur to these conditions and policies. I authorize my insurance company to pay all insurance benefits for service rendered.

KNOW YOUR BENEFITS

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance. I understand and agree that it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements, or any other type of benefit limitation for the services I receive and I agree to make payment in full. I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered. I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

_____	_____	_____
Print Name of Patient	Signature of Patient or Guardian	Date

DO WE HAVE PERMISSION TO LEAVE A MESSAGE WITH A PERSON OR MACHINE REGARDING SPECIFIC INFORMATION ABOUT YOUR APPOINTMENT TIMES AND DATES? [ ] YES [ ] NO