PERFORMANCE CHIROPRACTIC
POTENTIAL • PERFORMANCE • PERFECTION

DR. VUONG VO, D.C.
1527 10TH ST. ■ MARYSVILLE WA 98270
PH: 360.547.4044 ■ FAX: 360.547.4045
performance.chiropractic.wa@gmail.com

# NEW PATIENT REGISTRATION

Today's Date _____

Name _____
Last First Middle

Address _____
Street Apt# City State Zip

Social Security# _____ – _____ – _____ Date of Birth _____/_____/_____

Home Phone# (_____) _____–_____ Work Phone# (_____) _____–_____

Cell Phone# (_____) _____–_____ E-mail Address _____

Emergency Contact _____ Relationship _____ Phone# (_____) _____–_____

Employer _____ Occupation _____ Phone# (_____) _____–_____

Did a current patient refer you to this office? Circle One YES NO
If yes, who? _____

Is this visit due to an accident/injury/other _____ If Accident or Injury (Date) _____

## RESPONSIBLE PARTY INFORMATION

- **If patient is same as responsible party, skip this part and sign down below.**

Name (Guarantor) _____ Relationship to Patient _____
Last First M.I.

Address _____ Phone# (_____) _____–_____
Street City State Zip

Employer _____

Address _____ Phone# (_____) _____–_____
Street City State Zip

**By signing this application I affirm under penalty that I have given true complete information.**

_____ _____
**Patient Signature** **Date**

_____ _____
**Guarantor Signature** **Date**

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# CONSENT FOR PURPOSES OF HEALTHCARE OPERATIONS

I, _____ consent to **PERFORMANCE CHIROPRACTIC** use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for **PERFORMANCE CHIROPRACTIC**'s general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that **PERFORMANCE CHIROPRACTIC** diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent "Protected Health Information" means any information, including my demographic information, created or received by **PERFORMANCE CHIROPRACTIC**, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of **PERFORMANCE CHIROPRACTIC**, but that **PERFORMANCE CHIROPRACTIC** is not required to agree to these restrictions. However, if **PERFORMANCE CHIROPRACTIC** agrees to a restriction that I request, the restriction is binding on **PERFORMANCE CHIROPRACTIC**.

I have been given the opportunity to review **PERFORMANCE CHIROPRACTIC** Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information. This document is posted in plain view on the front desk near the intake window. Please notify our front desk if you wish to have a copy of our Notice of Privacy practices.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or **PERFORMANCE CHIROPRACTIC** has acted in reliance on this consent.

_____ _____

**Patient Signature** **Date**

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# PERFORMANCE CHIROPRACTIC FINANCIAL POLICY

1) We accept cash, Visa and MasterCard.
2) All payments are due at the time of service, unless special arrangements have been agreed upon prior to visit.
3) Regardless of insurance coverage you may have, you are held **liable** for any charges incurred as a result of services rendered to me at PERFORMANCE CHIROPRACTIC.
4) All co-pays will be due at the time of service, once your insurance coverage has been verified and we have established what your responsibility is.
5) As a courtesy to our patients, we will bill your insurance company for you. Please keep in mind that if there is a discrepancy, we will let you know as soon as possible; however, we will not get involved with any dispute between you and your insurance carrier.
6) If you have a credit balance, we will reimburse you after payment has been received.
7) All supplements/vitamins, lab work, supports and other supplies **must** be paid for at the time they are received.
8) You are responsible for timely payment of your account.
9) If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collections.

## Workers Compensation Claims

10) All workers compensation cases will be billed directly to the insurance company, providing the appropriate paper work has been filled out and a claim is filed. If the claim is denied, we will bill your private insurance carrier, if you have coverage. Please keep in mind that if your claim is denied, then you are responsible for prompt payment of your account.

## Personal Injury/Motor Vehicle Accidents

11) Personal injury and auto accident cases will be billed to your auto insurance company, providing that a claim has been filed and the appropriate paper work has been done.
12) Keep in mind we do not do third party billings to other insurance companies.
13) If you choose not to file a claim with your auto insurance company, or are uninsured, your account will be treated as a cash account, and all fees will be due at the time of service.

**I have read, understand and agree with the above financial policy.**

_____ _____
**Patient Signature** **Date**

_____ _____
**Guarantor Signature** **Date**

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# CONSENT TO CHIROPRACTIC TREATMENT

**The nature of chiropractic treatment:** I hereby authorize **PERFORMANCE CHIROPRACTIC** to provide Chiropractic Services for me. I acknowledge the doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, Graston Technique, and other manual muscle therapies may also be used.

**Possible Risks:** As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

**Probability of risks occurring:** The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

**Other treatment options that could be considered** may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

**Please read the following carefully and initial the statement.**

_____ I understand that I play an important role in my own health care. Just as a patient can choose to discontinue care at any time, **PERFORMANCE CHIROPRACTIC** reserves the right to terminate a doctor-patient relationship if a patient is continually unable to comply with reasonable treatment plans.

**I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.**

_____ _____

**Patient Signature** **Date**

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## PATIENT RIGHTS

We believe that all patients should be treated in a manner that respects their basic rights as human beings. You, as patients, have the right to:

1. Voice grievances or concerns about your care, or about the manner in which you were treated by the doctor or staff.

2. Receive clear and complete information about your care and participate in the decisions concerning your treatment. If you have concerns about the front desk staff, insurance or billing, please contact the Operations Manager.

3. Be treated with respect and courtesy by all those involved in providing care and information.

4. Privacy during interviews and examinations. All information about a patient's care and records will be treated in a confidential manner.

## PATIENT RESPONSIBILITIES

1. Be as accurate and complete as possible when providing information about your medical history or condition.

2. Cooperate in following instructions given to you by those providing your health care.

3. Read and cooperate with the instructions provided by your doctor.

4. Ask for clarification about any aspect of your health care benefits that you do not fully understand.

5. Keep scheduled appointments or give adequate notice of delay or cancellation.

6. Treat those caring for you with respect and courtesy.