CHAN CHIROPRACTIC and Massage

Theodore W. Chan, B.S., D.C.
Aaron W. Chan, B.S., D.C.
Keven M. Child, D.C.

4339 W. Kennewick, Ave., Kennewick, WA 99336
Ph: 509-735-0311 Fax: 509-783-1206

Name: _____ Date: / /
Last First M.I.

Address: _____
Street City State Zip

❑Male ❑Female

Home Phone: ( ) _____ Cell Phone: ( ) _____

❑Married ❑Widowed
❑Single ❑Divorced

E-mail _____ Age: _____

Soc. Sec. No.: _____ Birth Date: / /
MM/DD/YYYY

Spouse: _____ Referred By: _____
Last First M.I.

Patient's nearest relative: _____ Phone: _____

Employment Information

Employer: _____ Occupation: _____

Address: _____ Phone: _____
Street City State Zip

Insurance Information

Insurance Company: _____ ❑Auto Accident ❑Workers Compensation

Please make sure we have a copy of your insurance card and all necessary insurance information.

Complaint Information

Purpose of this appointment (Major Complaint): _____ (Please indicate on pain drawing)

When did you first notice the pain/symptoms? _____

How often do you experience your symptoms? ❑Constantly (76-100% of the time) ❑Frequently (51-75% of the time)
❑Occasionally (26-50% of the time) ❑Intermittently (1-25% of the time)

How are your symptoms changing with time?
❑Getting Worse ❑Staying the Same ❑Getting Better

How much has the problem interfered with your work?
❑Not at all ❑A little bit ❑Moderately ❑Quite a bit ❑Extremely

How much has the problem interfered with your social activities?
❑Not at all ❑A little bit ❑Moderately ❑Quite a bit ❑Extremely

How do you think your problem began? _____

Do you consider your problem to be severe? ❑Yes ❑Yes, at times ❑No

What activities aggravate your condition? _____

What concerns you the most about your problem; what does it prevent you from doing?

Have you lost any days from work? ❑Yes ❑No

Other doctors seen for this condition: ❑MD/DO ❑PT ❑MT ❑DC ❑other: _____

Past History

Have you been treated for any health conditions by a physician in the last year? ❑Yes ❑No

Describe: _____

What medications, vitamins, or drugs are you taking? _____

What operations have you had? _____

Describe any serious illnesses: _____

Have you ever been under Chiropractic Care? ❑Yes ❑No Doctor's Name:

Review of Systems

Have you Ever Suffered From:

Now	Past	Condition	Please Describe	Now	Past	Condition	Please Describe
❑	❑	Asthma		❑	❑	Frequent Urination	
❑	❑	Allergies/Hay Fever		❑	❑	Prostate Trouble	
❑	❑	Colds/Sinus Infection		❑	❑	Hemorroids	
❑	❑	Difficulty Breathing		❑	❑	Venereal Disease	
❑	❑	Headaches		❑	❑	Bruising Easily	
❑	❑	Dizziness		❑	❑	Itching	
❑	❑	Eye Pain/Failing Vision		❑	❑	Bursitis/Arthritis	
❑	❑	Deafness/Ear Noises		❑	❑	Varicose Veins	
❑	❑	Nosebleeds		❑	❑	Anemia/Fatigue	
❑	❑	High/Low Blood Pressure		❑	❑	Swelling of Ankles/Joints	
❑	❑	Rapid/Slow Hear Rate		❑	❑	Poor Circulation	
❑	❑	Nervousness/Depression		❑	❑	Cramps or Backache	
❑	❑	Kidney Infection or Stones		❑	❑	Irregular Cycle/Excessive Menstrual Flow	
❑	❑	Indigestion/Nausea		❑	❑	Lumps in Breast	
❑	❑	Ulcers		❑	❑	Hot Flashes	
❑	❑	Colon Trouble/Diarrhea		❑	❑	Foot Trouble	

Activities of Daily Living

Habits:	Heavy	Moderate	Light	None
Alcohol				
Coffee				
Tobacco				
Drugs				
Exercise				
Sleep				
Appetite				

Are you wearing:

❑Heel Lifts ❑Sole Lifts
❑Inner Soles ❑Arch Supports

What activities do you do at work?

❑Sit:	❑Most of the day	❑Half of the day	❑A little of the day
❑Stand:	❑Most of the day	❑Half of the day	❑A little of the day
❑Computer work:	❑Most of the day	❑Half of the day	❑A little of the day
❑On the phone:	❑Most of the day	❑Half of the day	❑A little of the day

Have you ever been hospitalized? ❑Yes ❑No

If yes, why: _____

What would you rate your overall health? ❑Excellent ❑Very Good ❑Good ❑Fair ❑Poor

What type of exercise do you do? ❑Strenuous ❑Moderate ❑Light ❑None

Indicate if you have any immediate family members with any of the following:

❑Rheumatoid Arthritis ❑Diabetes ❑Lupus
❑Heart Problems ❑Cancer ❑ALS

PAYMENT IS EXPECTED AT TIME OF VISIT!

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any insurance claim forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt. I also give this office power of attorney to endorse checks made out to me, to be credited to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. Should no payment be received on my account for sixty days there will be a 1.5% or $2.00 minimum service charge added to the account each month.

Patient's Signature: _____ Date: _____

Gaurdian or Spouse's Signature Authorizing Care: _____ Date: _____

Information Taken By: _____ Date: _____

Comments: _____

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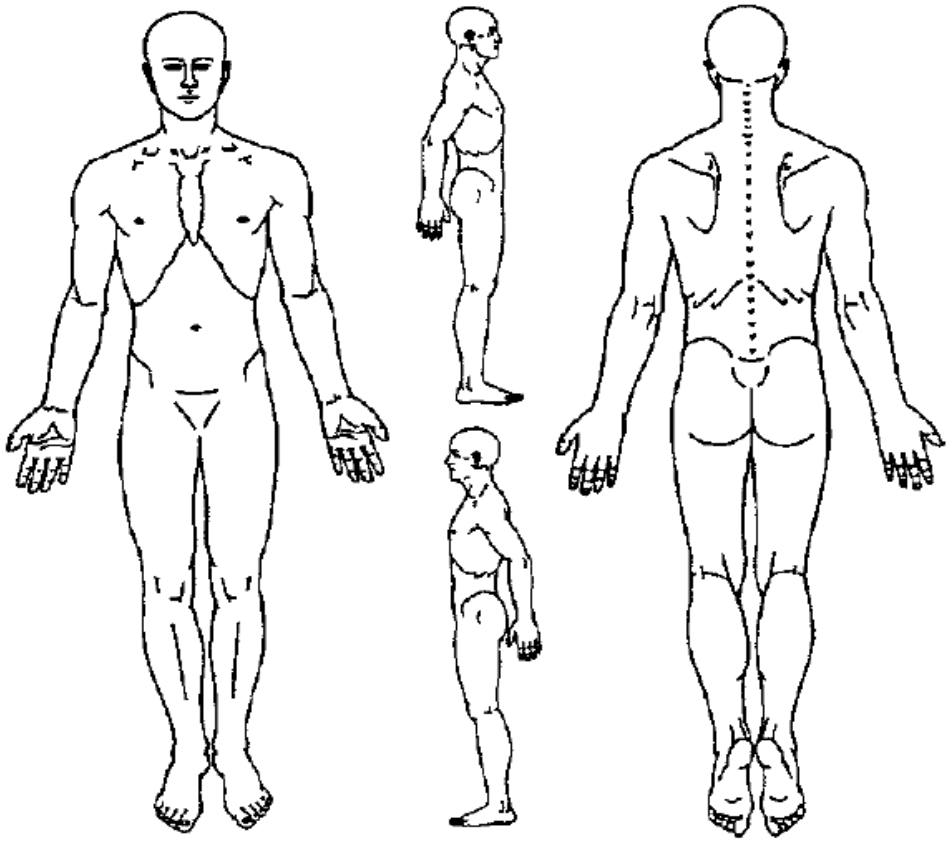
Pain Drawing Quadruple Index

Patient Name(Print)_____ Date_____

Patient ID#_____

Please circle the location of pain or discomfort on the images below. Use the letters shown to represent the type of pain:

D=Dull/Achy
ST=Stabbing/Cutting
B=Burning
T=Tingling
(Pins&Needles)
N=Numb
S=Shooting
C=Cramping



On the scales below, please draw a vertical line representing your pain or discomfort.

Rate the pain you have right **NOW**:

No Pain *Unbearable Pain*

Rate your pain at its **BEST** in the past week:

No Pain *Unbearable Pain*

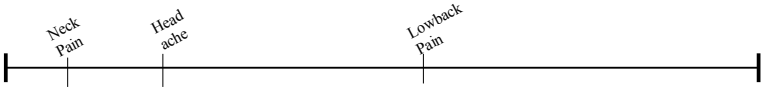
Rate your **AVERAGE** pain in the past week:

No Pain *Unbearable Pain*

Rate your **WORST** pain in the past week:

No Pain *Unbearable Pain*

example:



Chan Chiropractic and Massage

Office Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy that we require you read and sign prior to any treatment.

FULL PAYMENT (DEDUCTIBLES AND CO-PAYS) IS DUE AT TIME OF SERVICE.
WE ACCEPT CASH, CHECKS AND MOST CREDIT CARDS.
WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR APPROVAL.

Regarding Insurance:
We may accept assignment of insurance benefits. However, we do require 50% of the bill to be paid at time of service unless arrangements are made with the doctor. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information and/or an original claim form. **Your insurance policy is a contract between your insurance company and you.** We are not a party to that contract. If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to you for payment. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare program and/or other medical insurances.

Authorization Requirements:
When insurance companies require pre-authorization, we will apply on your behalf. However, your insurance company may refuse to authorize the treatment plan recommended by the doctor. You will be financially responsible for the non-authorized visits.

Usual and Customary Rates:
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payments regardless of any insurance company's arbitrary determination of usual and/or customary rates.

Adult and Minor Patients:
Adult patients are responsible for full payment at time of service. The adult accompanying a minor and the parents (or legal guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless arrangements have been made for payment by cash or check at time of service.

Missed Appointments:
Unless canceled at least 24 hours in advance, we reserve the right to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping your scheduled appointments. By signing this form you are agreeing to permit Chan Chiropractic and Massage and its employees to contact you via the provided contact methods for appointment reminders and followup (such as text, email, home or cell phone and USPS).

Third Party Payment:
In certain cases, a third party may be responsible for payment of your account. We may hold any outstanding bills and file a medical lien to secure the payment of this debt. The lien will be filed with the County Auditor's office and will remain on file until the account is settled or the claim is closed, at which time payment is due. A charge for processing the lien and administrative fees will be applied to your account balance.

I have read the Financial Policy. I understand and agree to this Financial Policy: I hereby assign payment of Insurance benefits to Chan Chiropractic Clinic, P.S.

X _____ _____
Signature of Patient or Responsible Party — Date

X _____ _____
Signature of Co-Responsible Party — Date

The Chan Institute of Health and Wellness
4339 West Kennewick Avenue
Kennewick, Washington 99336-2802
509-735-0311

Consent for Purposes of Treatment, Payment & Healthcare Operations (6/04)

In this document, "I" and "my" refer to the patient,
and "Institute" refers to The Chan Institute of Health and Wellness.

I consent to the use or disclosure of my protected health information by Institute for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Institute. I understand that analysis, diagnosis or treatment of me by Institute may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Institute is not required to agree to the restrictions that I may request. However, if Institute agrees to a restriction that I request, the restriction is binding on Institute.
I have the right to revoke this consent, in writing, at any time, except to the extent that Institute has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Institute and understand that I have a right to a copy of the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Institute. The Notice of Privacy Practices for Institute is also posted in the waiting room at 4339 W. Kennewick Ave., Kennewick, WA 99336. This Notice of Privacy Practices also describes my rights and duties of the Institute with respect to my protected health information.

Institute reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Institute and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____
Signature of Patient or Personal Representative Printed Name of Patient

_____ _____
Date of Signing Description of Personal Representative's Authority

Informed Consent for Therapeutic Massage

I understand that the therapeutic massage I receive is provided for stress reduction, relaxation, relief from muscular tension, and improvement of circulation and energy flow.

If I experience pain or discomfort during the session, I will immediately inform my practitioner so that the pressure and/or strokes can be adjusted to my level of comfort. I will not hold my practitioner responsible for any pain or discomfort I experience during or after the session.

I further understand that the services offered today should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a medical physician, chiropractic physician, or other qualified medical specialist for any mental or physical ailment of which I am aware.

I understand that my practitioner is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness, and that nothing said in the course of the session 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 practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.

I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

*** We ask for a 24 hour notice if you are not able to make your appointment. If you fail to cancel in a timely manner and/or do not show up to your appointment you will incur a $40.00 service fee.***

Please help us serve you better by keeping your scheduled appointments. By signing this form you are agreeing to permit Chan Chiropractic and Massage and its employees to contact you via the provided contact methods for appointment reminders and followup (such as text, email, home or cell phone and USPS).

_____	_____	_____
Print Name	Signature	Date

Consent to treat a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive therapeutic massage.

Information and Suggestions

- Prior to your massage, please remove contact lenses and all jewelry. Pull long hair back with a clip or band.
- In general, massage is given while you are unclothed. However, you may choose to wear undergarments or a swimsuit. You will be covered with a top sheet throughout your session. This is your massage and you should be as comfortable as possible.
- Feel free to ask your practitioner any questions before, during, or after the session. Your practitioner is a highly trained professional and will be happy to help you feel informed and comfortable.

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to 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. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

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.

PATIENT SIGNATURE **X** (Date)

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

OFFICE SIGNATURE **X** (Date)