Basin Family Chiropractic

2200 S. Maiers Rd, Suite B • Moses Lake, WA 98837 • Phone: (509) 764-8626 • Fax: (509) 764-8628

www.basinfamilychiropractic.com

NAME:_____ GENDER: ☐MALE ☐ FEMALE
LAST NAME FIRST NAME, LEGAL MIDDLE INITIAL

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

E-MAIL:_____ DOB:____/____/____ SS#:____/____/____

HIPPA Phone Authorization: I authorize Basin Family Chiropractic to leave messages on my voicemail in regards to information regarding appointments, treatment related issues, and billing issues
At the following number(s) checked below (you must specify at least one phone number) :

☐**E-MAIL** Listed Above☐[H](_____) _____-_____ ☐[W](_____) _____-_____ ☐[C](_____)_ _____-_____

HIPPA phone authorization other than patient: This authorization will remain in effect until you choose to revoke it. I authorize Basin Family Chiropractic to leave a message for, or speak to the specified individual(s) listed below in regards to information regarding appointments, treatment related issues and billing issues: (this person must provide us with your date of birth).
☐ At my home number with (name)_____
☐ At another number (_____-_____-_____) with (name)_____
You have the right to withdraw this authorization at any time. Such revocation must be in writing.

EMPLOYER:_____ CITY:_____ STATE:_____
MARITAL STATUS: Single Married Divorced Widowed Separated
PRIMARY INSURED'S NAME:_____ DOB____/____/____
EMERGENCY CONTACT(not living with you):_____PHONE (_____)_____-_____

Who may we thank for referring you? _____

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR PURPOSE OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS & FINANCIAL AGREEMENT : HIPPA I hereby authorize *Basin Family Chiropractic* to use and disclose the health & medical information, via fax, mail or electronically for the purpose of treatment, payment, and health care operations. I also authorize the physician to release any information to referring/consulting physicians or other health care providers, as your physician deems appropriate to facilitate my/our care. I hereby assign payment to be directly issued to *Basin Family Chiropractic* for any benefits available under my coverage and/or settlement for treatment and/or expenses incurred at this office. I agree that this Assignment of Benefits and Authorization to release information irrevocable and that I am waiving the statute of limitations for payment. I have been informed of the $20 fee on checks returned. In the event the account goes to collection I agree to pay interest, collection fees, and will not withhold/delay payment, and that I am responsible for my/my child's bill. **I understand that I am responsible for knowing my medical benefits/limits/ exclusions.**

WAIVER FOR PAYMENT OF NON-COVERED OR EXCLUDED MEDICAL SERVICES: non-covered or excluded medical services are identified in the information your health care plan provided to you. Additional examples of non-covered services may include: "maintenance or palliative care" chiropractic treatment(s), manual massage, manual traction, trigger point therapy, exercise instructions, re-exams, medical equipment, treatment without a referral and/or authorization, and missed massage appointments. Medicare follows guidelines under Section 1862 (a) (1) of the Social Security Act to determine which medical services are reasonable and necessary. Medicare will only cover spinal manipulations. Labor & Industries does not cover supplies. I understand that there may be certain procedures/supplies/charges that are not covered by my insurance/3rd party settlement, and agree that I am financially responsible for those charges.

☒CONSENT TO TREATMENT OF A MINOR: As parents or legal guardian, I have the authority to authorize, and do hereby grant the Chiropractor(s) at Basin Family Chiropractic, to administer chiropractic care as he/she deems necessary to my son/daughter/ward. I also agree to massage therapy by the LMP(s):

☞**Name of Minor**_____
☞**Print Adult Name**_____

My signature below acknowledges that I have reviewed, understand and agree to the HIPPA phone authorization, authorization to release information/assignment of benefits, financial policy, waiver for payment of non-covered/excluded services & consent to the treatment of a minor. By refusing to sign I understand that I, or my child will not be able to receive care in this office.

☞**PATIENT** (or Legal Guardian signature):_____ **DATE:** ____/____/____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care. We may conduct some diagnostic or examination procedures if indicated. And examinations or tests conducted will be done carefully. Treatment provided in this office include, but not limited to: spinal manipulation, traction, myofascial release, massage therapy and therapeutic exercise. Potential benefits of treatment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, improving neurological function and overall wellbeing. It is important that you understand, as with all health care approaches results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care including, but not limited to: muscle spasms, aggravation and/or scarring from hot or cold therapies, fractures, disc injuries, strokes, dislocations, strains and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. If you are experiencing neck pain with any difficulty speaking, double vision, slurred speech, difficulty moving or walking please tell the Doctor that you are experiencing these symptoms, because you may be experiencing an arterial dissection (which is an extremely rare event).

It is also important that you understand there are treatment options available for your condition other than our office procedures. Likely, you have tried many of these approaches already. There options may include, but are not limited to: self-administered care, over the counter pain relievers, rest, medical care with prescription medication, physical therapy, bracing, injections and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I understand that it is not possible to consider every complication to care. I have also had an opportunity to ask questions about its content and by signing below, I agree with the current or future recommendations to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all the providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office. I have read, or have had read to me, the above consent.

Patient Name:_____ Signature:_____ Date:_____

Basin Family Chiropractic

2200 S. Maiers Rd, Suite B • Moses Lake, WA 98837 • Phone: (509) 764-8626 • Fax: (509) 764-8628

www.basinfamilychiropractic.com

MASSAGE

Patient Name: _____ **Date:** ___/___/_____

Have you ever had a professional massage before? ☐ **Yes** ☐ **No**

What are your expectations from massage? _____

_____

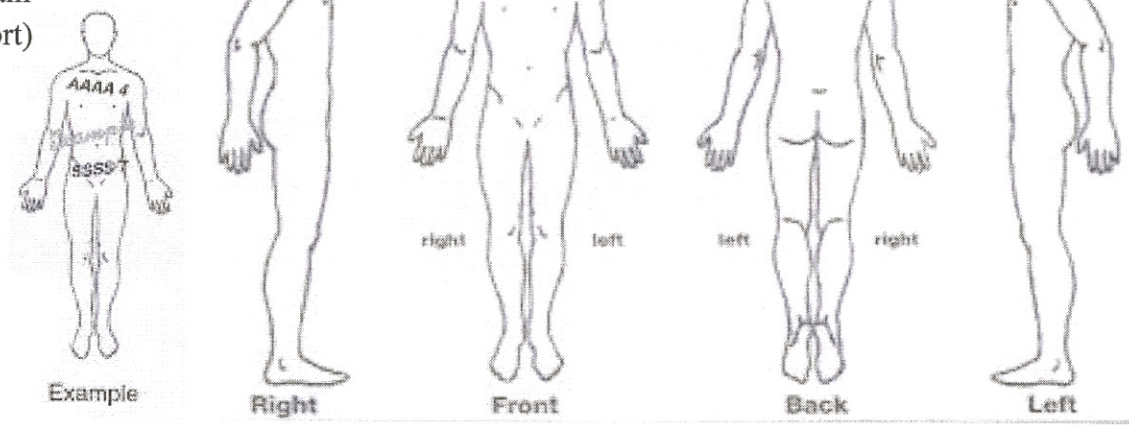
Any other information you would like the therapist to know? _____

_____

When did your problem begin? ☐ **Immediately after a specific incident** ☐ **Multiple incidents** ☐ **Gradually Developed** ☐ **No Specific incident - Please list "incident/s":** _____

Pain Diagram: Use symbols below to mark the figures. Mark all areas using pain scale from 1 (discomfort) to 10 (extreme pain).

Description:
AAA = Aching
NNN = Numbness
SSSS = Stabbing
BBB = Burning
PPPP = Pins/Needles
TTT = Throbbing



Frequency (overall): ☐Constant (76-100%) ☐Frequent (51-75%) ☐Occasional (26-50%) ☐Intermittent (0-49%)

Your general stress level: ☐ No Stress ☐Minimal Stress ☐Moderate Stress ☐Greatly Stressed
Physical Activity at work: ☐Sitting 75% of day ☐Light Manual Labor ☐Manual Labor ☐Heavy Labor
General Physical Activity: ☐No Regular Exercise ☐Light Exercise Program ☐Strenuous exercise program
Are you currently pregnant? Yes/No
Allergies: _____

Personal Health History

PAST	PRESENT		PAST	PRESENT	
☐	☐	Neck Pain	☐	☐	Pain in Ankle or foot
☐	☐	Shoulder Pain	☐	☐	Pain in lower leg or knee
☐	☐	Pain in Upper arm or elbow	☐	☐	Cancer
☐	☐	Hand Pain	☐	☐	Pain in upper leg or hip
☐	☐	Wrist Pain	☐	☐	Low Back Pain
			☐	☐	High Blood Pressure

☐ Surgeries: _____

_____

I understand and agree that the following information on this form is accurate, current and will be confidential. It is my responsibility to keep my massage therapist informed of any changes in my health and any medications that I might take in the future. Please feel free to adjust the depth/techniques of the massage treatment at any time by telling the therapist. Please inform the therapist if you have a communicable disease. They reserve the right to refuse service for safety and health concerns.

Signature: _____

Basin Family Chiropractic

2200 S. Maiers Rd, Suite B • Moses Lake, WA 98837 • Phone: (509) 764-8626 • Fax: (509) 764-8628

www.basinfamilychiropractic.com

MASSAGE

____POLICIES, PROCEDEURES & FINANCIAL AGREEMENT____

SIGNING IN

When you arrive, please sign in. You will be called for your appointment at the time you were scheduled.

APPOINTMENT TIMES

We will set a specific time for your appointment. Try to be prompt, as the therapist has set this time aside to provide you with appropriate time needed for your particular treatment. If you come at another time, your treatment will either be cut short or rescheduled. We value your time. If you wish to sit down and discuss your care, a specific Provider/Patient conference will be scheduled at no additional charge.

MISSING OR CHANGING APPOINTMENTS

Our massage therapist has set aside a specific number of treatment times available each day, due to the fact that appointments are scheduled allowing anywhere between 30 - 60 minutes each, it is very important that you allow an adequate amount of time to arrive at the office prior to your appointment time. If for some reason you need to change or cancel your appointment, call at least 24 hours prior to your scheduled time (If your appointment falls on a Monday please make sure to notify our office, during business hours, the previous business day.), to allow us time to fill the opening.

If you do not call 24 hours before your appointment time, or miss your appointment completely, you will be charged a no-show fee of $35.00

This fee will have to be paid prior to any further services being rendered.

If you no-show 3 appointments you will no longer have the opportunity to schedule further appointments with our massage therapist.

PAYMENT OF ACCOUNT

Because a massage therapy appointment is not a frequent appointment, all payments will be due at the time of service. If we are billing your insurance for services, your portion is also expected at the time of service. Our office does not send out monthly statements. It is your responsibility to keep your account up to date. If billing statements have to be sent there will be a $5.00 billing fee applied to the account monthly until it is paid in full. Any unpaid balances will be sent to a collection agency after 2 months of non-payment. If you terminate care at any time, your portion of all charges is immediately due and payable to Basin Family Chiropractic.

I have read and agree to the above.

Signature _____ Date_____

Witness_____ Date_____

Basin Family Chiropractic

2200 S. Maiers Rd, Suite B • Moses Lake, WA 98837 • Phone: (509) 764-8626 • Fax: (509) 764-8628

www.basinfamilychiropractic.com

Massage

Text Message Reminder

As a courtesy to our patients we are now offering the option for massage reminders to be made via Text Message. We understand that this may be a better option for some, but not for everyone. Included in the message will be your date and time for massage. The service will be free aside from standard text messaging rates that will apply to your carrier. Please check below the option that you would prefer for your massage reminder.

☐ Phone Call

☐ Text Message Cell Number:_____ Carrier_____

Name_____

Signature_____ Date_____

Witness_____ Date_____

Basin Family Chiropractic

2200 S. Maiers Rd, Suite B • Moses Lake, WA 98837 • Phone: (509) 764-8626 • Fax: (509) 764-8628

www.basinfamilychiropractic.com

Name of Patient: _____

Patient Date of Birth: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of Provider's Notice of Privacy Practices with the effective date of _____.

_____ _____

Signature of Patient/Patient Representative Date

_____

Relationship to Patient

Office Use Only

Documentation of Good Faith Efforts To obtain patient's acknowledgement that they received provider's Notice of Privacy Practices

(For use when acknowledgement cannot be obtained from the patient.)

The patient presented to the office on _____/_____/_____ and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the notice. However, such acknowledgement was not obtained because:

☐ Patient Refused to Sign

☐ Patient was unable to sign or initial because:

_____

☐ The patient had a medical emergency, and an attempt to obtain the acknowledgement will be made at the next available opportunity.

☐ Other reason (describe below):

_____

Signature of Employee Completing Form: _____

Date Signed: _____/_____/_____