

FINANCIAL POLICIES & AUTHORIZATION

Genesis Chiropractic Rehabilitation NW
12815 Canyon Road E, Ste. K
Puyallup, WA 98373
(253) 256-4769

Payment Policy

YOU ARE ULTIMATELY RESPONSIBLE FOR THE PAYMENT OF YOUR ACCOUNT.

PATIENTS WITH INSURANCE: If your medical insurance policy provides benefits for chiropractic, rehab, or massage, we will be happy to submit a claim to them on your behalf. You are expected to pay your estimated portion at the time services are rendered. This may be in the form of co-pays, co-insurance and/or deductibles. Your estimate portion will be calculated by the benefit information we receive from your insurance company. A benefit quote is not a guarantee of payment.

Patients who are treating on worker's compensation or motor vehicle collision claims are required to get us the proper insurance information and referrals:

Worker's Compensation: Worker's compensation does cover chiropractic, rehab, and massage if your claim has been approved and is currently open. If the claim is not allowed or it is denied, it is your responsibility to pay the outstanding balances.

Motor Vehicle Collisions: Your auto insurance will pay for collision-related chiropractic, rehab, and massage therapy if you have PIP (Personal Injury Protection) coverage included in your policy at the time of the collision. You must file a claim with your insurance company and complete & return a PIP Application to them before they will issue any payment toward your account. If charges are denied or your PIP benefits become exhausted, it is your responsibility to pay the outstanding balances.

3rd Party Accidents: In the case of a motor vehicle accident where there is no personal injury protection or adequate health insurance, a monthly payment of \$100.00 is required toward your balance until your case settles, at which point the remaining balance will be due. This monthly payment is not necessary when you are working with an attorney to settle your claim.

PATIENTS WHEN INSURANCE DOESN'T APPLY: We offer a time of service discount for patients with limited insurance benefits or no insurance coverage for chiropractic, rehab, and massage.

I have read the above policy of Genesis Chiropractic and fully understand that I am responsible for the payment of my account.

Initial _____

Cancellation Policy

We would like to stress the importance of receiving chiropractic, rehab, and massage therapy regularly, especially for the rehabilitation of an injury. If you receive treatments on schedule, the success and benefits will be greatly increased, and recovery time will be quicker.

In respect to you and to us, we will need twenty-four (24) hour notice of cancellation of appointments (except in emergencies). If we are not notified in a timely manner, you may be charged a Cancellation Fee up to 50% of your scheduled appointment and treatment will not resume until payment is received. By letting us know in advance, we can fill your spot with another patient awaiting treatment. **IF TWO OR MORE APPOINTMENTS ARE LATE, CANCELLED, OR MISSED, WE MAY CANCEL ALL STANDING APPOINTMENTS UNTIL PAYMENT IS RECEIVED.**

I have read the above policy of Genesis Chiropractic and fully understand that I am responsible for the payment of my account.

Initial _____

Massage Therapy

I understand my treatment may involve the use of oils, lotions and hot and/or cold packs necessitating the need for me to remove some or most of my clothing. During this time, I understand I will be draped appropriately with linens for warmth and privacy. Only the specific area being treated will be undraped. If a session necessitates removal of clothing, and I would prefer to remain clothed, I will inform my practitioner. I understand that Genesis Chiropractic massage therapists

do not diagnose illnesses or prescribe medical or pharmaceutical treatment. It is my choice to receive massage therapy and I have provided accurate information concerning all past and current health conditions. I further agree to report any changes in my health should they arise.

I have read the above policy of Genesis Chiropractic and fully understand that I am responsible for the payment of my account.

Initial _____

Right of Refusal

We reserve the right to refuse service to anyone at any time without explanation.

Notice of Privacy Practices Acknowledgement (HIPAA)

We keep a record of the health care services we provide to you. You may ask to see and copy those records. You may ask to correct those records. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or requires us to do so. You may also see your records or get more information by contacting a Genesis Chiropractic staff member. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed and how you can access your information. A copy of said Notice is available upon request.

Authorization to Bill Insurance

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate to any insurance company, attorney, or adjuster to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney, out of the proceeds of any settlement and/or by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payments to me or to you for services rendered refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such insurance company and authorize you to prosecute said action in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you seem fit. I understand that whatever amounts not collected by the insurance company's proceeds, whether it is all or part of what is due, I personally owe and agree to pay you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in the State of Washington.
5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.
6. This Authorization will be in continual effect until revoked by both parties.

Consent for Electronic Communications (Text/Email)

I authorize Genesis Chiropractic Rehabilitation NW to communicate with me via text message and/or email for appointment reminders, billing, or treatment information. I understand that while reasonable safeguards are used, electronic communications may not be fully secure.

I have read and I understand the above content including the payment policy, cancellation policy, massage therapy notice, right of refusal, notice of privacy practices, authorization to bill insurance, and consent for electronic communication. I agree to comply with all that is stated above.

Patient Name (printed)

Patient Signature (if minor, parent or guardian)

Date

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had the opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts known, is my best interest.

I have read, and or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition (s) for which I seek treatment.

To be completed by patient:

Print Patient's Name

Signature of Patient

Date Signed

To be completed by doctor or staff:

Name and address of clinic/office:

Print name (s) doctor (s) treating this patient:

12815 CANYON RD Suite K
Suite K

X

NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____

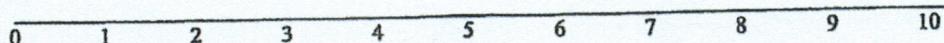
Date _____

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain

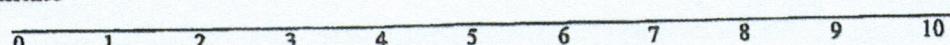
Worst pain possible



2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference

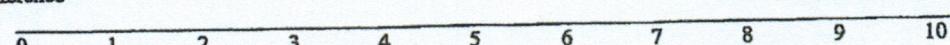
Unable to carry out activity



3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference

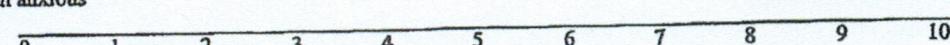
Unable to carry out activity



4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious

Extremely anxious



5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed

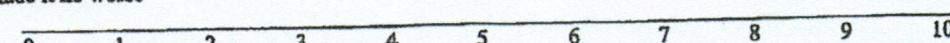
Extremely depressed



6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse

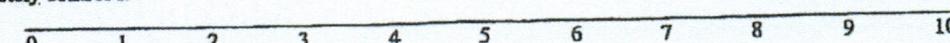
Have made it much worse



7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it

No control whatsoever



Examiner _____

OTHER COMMENTS: _____

BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____

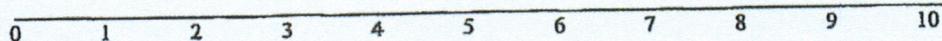
Date _____

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain

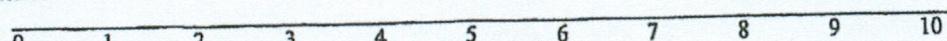
Worst pain possible



2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference

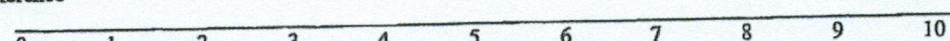
Unable to carry out activity



3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference

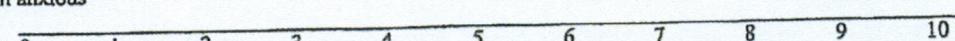
Unable to carry out activity



4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious

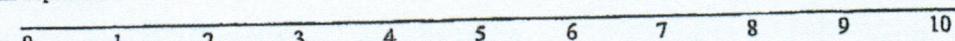
Extremely anxious



5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed

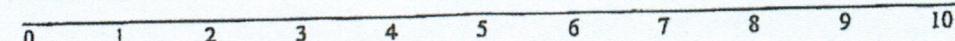
Extremely depressed



6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse

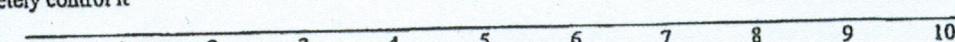
Have made it much worse



7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it

No control whatsoever



Examiner _____

OTHER COMMENTS: _____

CHIROPRACTIC REGISTRATION AND HISTORY

1

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name _____

First Name _____ Middle Initial _____

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex M F Age _____

Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

3

PHONE NUMBERS

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

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

2

INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Name of Insurance Company(ies) _____

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date

Relationship to Patient

4

ACCIDENT INFORMATION

Is condition due to an accident? Yes No Date _____

Type of accident Auto Work Home Other

To whom have you made a report of your accident?

Auto Insurance Employer Worker Comp. Other

Attorney Name (if applicable) _____

5

PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

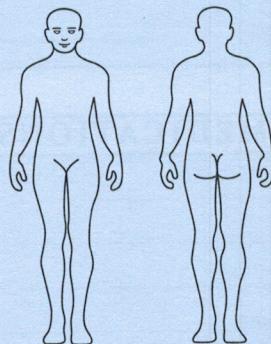
Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down



6

HEALTH HISTORY

What treatment have you already received for your condition? Medications Surgery Physical Therapy

Chiropractic Services None Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
 Spinal Exam _____ Chest X-Ray _____ Urine Test _____
 Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually Transmitted Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____	
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No		

EXERCISE	WORK ACTIVITY	HABITS
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Smoking _____
<input type="checkbox"/> Moderate	<input type="checkbox"/> Standing	<input type="checkbox"/> Alcohol _____
<input type="checkbox"/> Daily	<input type="checkbox"/> Light Labor	<input type="checkbox"/> Coffee/Caffeine Drinks _____
<input type="checkbox"/> Heavy	<input type="checkbox"/> Heavy Labor	<input type="checkbox"/> High Stress Level _____
		Reason _____

Are you pregnant? Yes No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

7	MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
	_____	_____	_____
	_____	_____	_____

Pharmacy Name _____

Pharmacy Phone (_____) _____