Ellensburg Chiropractic PS

109 South Water Street, Ste2
Ellensburg, WA 98926
Ph: 509-962-2225
Fx: 509-962-2270

Full Name: _____
Last: First: Middle Intial:

Mailing Address: _____
Street Address: Apartment #

_____
City: State: Zip Code:

Cell Phone: _____ Home Phone: _____

Date of Birth: _____ Age: _____

Social Security #: _____

Emergency Info: _____
Contact Person: Contact's Phone #:

Gender: __Male __Female ***If you are a female, are you pregnant:* __*Yes* __*No*

Height: ____ft ____in Weight: ____lbs

What is your smoking status? __Never Smoked __Former Smoker __Current Smoker

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Marital Status *(Check One)* : __Single __Married __Divorced __Widowed

Primary Language *(Check One)* : __Decline to answer __Arabic __English __Spanish __Other

Race *(Check One)* : __Decline to answer __Asian __African American __Caucasian __Other

Ethnicity *(Check One)* : __Decline to answer __Not Hispanic or Latino __Hispanic or Latino

How did you hear about us *(Check One)* : __Drove By __Newspaper/Radio __Physician __Friend: _____

If you are a minor, under the age of eighteen (18), fill out the below information:

Who is the responsible party or your legal guardian:
__Father __ Mother __Other; Specify: _____

Fill out the below information with the responsible party's information:

Full Name: _____
Last: First: Middle Intial:

Mailing Address: _____
Street Address: Apartment #

_____
City: State: Zip Code:

Cell Phone: _____ Home Phone: _____

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List all areas of the body are bothering you:

_____

What caused the areas of the body to have issues (**BE SPECIFIC**. ie: fell, auto accident, slept wrong, working out, driving):

_____

_____

When did your symptoms begin or when did they recently flare up again:

__Today __Yesterday __Last Week __Two Weeks Ago __Last Month
__Other; specify date: _____

How often do you experience discomfort:

__Constant (75-100% of awake time) __Frequent (51-75% of awake time)
__Intermitten (26-50% of awake time) __Occasional (0-25% of awake time)

What activites are limited by your discomfort:

__Bending __Bowel Movements/Urination __Coughing __Daily Routine __Driving
__Getting Up __Lifting __Laying Down __Pulling __Pushing __Reading
__Sitting __Sleeping __Sneezing __Standing __Turning My Head __Walking

Do you have any radiating pain or numbness in the following areas:

__In my arm(s) __In my thigh/leg(s)
__In my hand(s) __In my foot/feet

Please specify the most recent date of the following services:

Physical Exam: ____month, ____year MRI: ____month, ____year
Spinal Xray: ____month, ____year CT Scan: ____month, ____year

My pain is reduced when I use:

__ice __heat __advil/ibuprofen/asprin
__massage __nothing helps __haven't tried to allievate my pain

List all the prescribed medications with the dosage levels you are currently taking:

_____

_____

List all the medications you are allergic to:

_____

_____

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Are you here due to an accident that you filed a claim on *(Check One)* :

__ Car Accident __ Work Accident __ Not Filing a Report or Claim/Not Applicable

Claim #: _____

Injury Date: _____

Rep's Name: _____

Rep's Phone #: _____

Are you the ***primary*** policy holder?

__ Yes (Check & Skip To Insurance Information)

__ No (Complete All Required Information Below)

The primary policy holder is:

__ Father __ Mother __ Spouse __ Other; Specify: _____

What type of insurance is this:

__ Primary __ Secondary __ Other: Specify: _____

Fill out the below information with the primary policy holder's information:

Full Name: _____
Last: First: Middle Intial:

Mailing Address: _____
Street Address: Apartment #

_____
City: State: Zip Code:

Cell Phone: _____ Home Phone: _____

Date of Birth: _____

Gender: __ Male __ Female

Fill out the below information regarding your insurance:

Insurance Company: _____

Mailing Address: _____
Street Address:

_____
City: State: Zip Code:

Customer Service #: _____ Effective Date: _____

Policy/Susbscriber #: _____ Group #: _____

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109 South Water Street Suite #2
Ellensburg WA 98926

Phone: 509.962.2225 **Dr. Gary L. Favero** Fax: 509.962.2270

NOTICE FOR THE POSSIBILITY OF INSURANCE DENIAL

As a courtesy to you, we will bill your insurance company directly. Please note that if we bill the insurance company for your services, you will not be eligible for our "paid at the time of service" discount, which is 30-50% off our regular and customary charges. However you are always welcome to take advantage of this discount by paying the discounted price at the time the services are rendered, and then you bill your insurance company for reimbursement. We will gladly provide you with the "superbill".

Your insurance company will only pay for services it determines to be reasonably necessary. If your insurance company determines that a particular service, although it would otherwise be covered, is not reasonably necessary under its program standards your insurance company will deny payment for that service. The following services may not be covered:

- Some or all x-rays
- Re-examinations
- Supplies such as pillows, exercise band, orthotics, supplements, etc.
- Manual traction/mechanical traction
- Office visits deemed "not medically necessary" by your insurance company
- Massage therapy
- Spinal rehabilitation and exercises

_____

I have been informed by my doctor or his staff that in my case, my insurance company may deny payment for some future services. If my insurance company denies payment, I agree to be personally and fully responsible for payment of these services. I understand that I could choose to pay discounted fee at the time of service, but, at this time, would like to bill my insurance and forfeit the "paid at time of service" discount.

I authorize any person or institution providing care or services, or any organization in possession of insurance or benefit information to release any and all information pertaining to the care or benefits provided to me. I authorize payments to be made directly to Ellensburg Chiropractic.

Patient Name (PRINT):_____

Patient Signature: _____ Date:____/____/____

Patient Health Information and Privacy Policy:

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available here http://www.cms.hhs.gov/SecurityStandard/Downloads/securityproposedrule.pdf

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient recevies care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligations. Staff have been trained in the area of patient record privacy and a privacy offical has been designated to enforce those procedures.
5. Patients have the right to file a formal compliant with our privacy offical about any suspected violations
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Inital_____

Consent to Professional Treatment

The patient certifies that all the information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of this treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for treatment of the child as provided for herein. The patient may refuse treatment at any time.

Inital_____

Consent to Perform and Interpret X-rays

The patient consents to the performance of xrays as deemed necessary by the attending physican of this office. The patient acknowledges that certain risks are associated with xrays. The patient hereby states that they have no known limitations that would forbaid the taking of xrays.

The patient further agrees that this office may seek outside interpretation of patient xrays by a qualified professionals not employed by this office. The patient agrees to any additional fees associated with this service and assigned benefits to be paid directly to that professional by third-party payor.

Inital_____

Assignment of Benefits and Release of Records

The patient hereby assigns benefits to be paid directly to this provider by all of their third-party payors. This assignment is irrevocable. Failure to fulfill this obligation will be considered a breach of contract between the patient and this office.

The patient authorizes this office to release any information required by a third-party payor necessary for reimbursment of charges incurred.

Inital_____

Financial Obligations and Appointment Policy

The patient accepts <u>full</u> financial responsibility for services rendered by this practice. This office reserves the right to charge fair market value for missed appointments or appointments canceled without any advance notification required by this office. Payment in full is required for all services at the time of visit, unless alternative arrangements have been agreed to in advance. Patient accepts full responsibility for any fees incurred, including but not limited to legal fees, collection agency fees, and any and all other incurred in the collection of past due accounts. Patient should direct any questions reqarding this financial obligation and appointment policy to the clinic manager or physician.

The patient further authorizes the practice to retain credit card, debit card and checking account or other payment source(s) supplied by the patient to the practice for current and future charges, when incurred.

Inital_____

Signature: _____ **Date:** _____