



## OFFICE POLICY

The following is an explanation of our client policies. We believe that a clear definition will allow us both to concentrate on the most important issue: regaining and maintaining your health. We will be happy to answer any questions you may have regarding our policies, your account, or your insurance coverage.

### **Patient Payment Policy**

We feel the patient's health needs are paramount; therefore, the following payment policy is an attempt to allow you, the patient, to receive the care you need and clear your balance with the least amount of difficulty.

### **New Patient Care Services**

We require a minimum of 25% of the first visit charges due on the first day of service. The balance of these charges may be made in payments over the next six weeks, unless we bill your insurance for payment. Properly documented workers' compensation and auto accident claims are not required to pay at this time if appropriate forms and letters of protection are signed.

### **Established Patient Care Services**

#### ***Patients with No Insurance***

All payments are expected at time of service. Patient balances may not exceed \$200.00 at any time, or professional services may be terminated.

#### ***Patients with Insurance***

Most insurance policies do cover chiropractic care. We will be happy to file your insurance claims for you and do everything we can to assure you receive proper reimbursement. However, we cannot take responsibility for what your health insurance will or will not cover. You must clearly understand and agree that all services rendered to you are charged directly to you and that you are personally responsible for payment. All copayments are expected at time of service. Patient balances may not exceed \$200.00 at any time, or professional services may be terminated.

Any balance due past 90 days will be sent to our collection agency and a \$30.00 collection fee will be added to your balance. There is a \$30.00 service fee for any returned checks.

### **Massage Therapy**

All massage charges are due at the time of service and no payment plans will be allowed. We will be happy to bill your insurance company after collecting any copay. We require 24 hours' notice for any cancellation. If less than 24 hours' notice is given, or if you miss your appointment without calling, you will be charged for your appointment in the amount of \$25.00 per half hour missed. We understand emergencies occur, and in special circumstances this fee may be waived.

### **Appointments**

In order to better serve our patients, we ask that you call if you are unable to make your appointment or if you will be late. Your appointment time is reserved for you. If you fail to notify our office, it leaves a time slot open that could be used to help someone else. Please help us help others. Additionally, should more than a 3 month period elapse between office visits, an evaluative exam is necessary prior to reinstating treatment.

### **Questions and Answers**

Your questions about any aspect of your care or account are invited. Please feel free to ask your doctor or any available staff member. We will make every effort to answer your inquiries. Lastly, it is the goal of this office to provide you with the finest quality chiropractic care available. We welcome your referrals and look forward to a doctor-patient relationship that works for our mutual benefit.

I, \_\_\_\_\_, have read the North Star Chiropractic Policies and will honor them,

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



# North Star Chiropractic Center

## CONFIDENTIAL PATIENT INFORMATION

Date \_\_\_\_\_ Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed Social Security \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone Number \_\_\_\_\_ Email \_\_\_\_\_

You will automatically be opted-in to text reminders. They will arrive 1 day prior, and 2 hour prior to your appt.

Occupation \_\_\_\_\_

Company \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Emergency Contact Phone Number \_\_\_\_\_

Is your visit due to a personal injury claim? Y N  
(If yes, please see front desk for personal injury intake forms)

### Referral Source:

- ☐ Website (i.e. Google/Yelp)  
☐ Social Media Ad (i.e. Facebook/Instagram)  
☐ Walk – In  
☐ Family/Friend \_\_\_\_\_  
☐ Insurance Provider List  
☐ Other \_\_\_\_\_

Your Present Complaint/Symptoms \_\_\_\_\_

Have You Been Treated by a Physician for Any Health Condition in the Last Year? Y N

Describe Condition \_\_\_\_\_ Date of Last Physical Exam \_\_\_\_\_

List All Medications Being Taken \_\_\_\_\_

List Any Allergies \_\_\_\_\_

Describe Any Operations You've Had & Dates \_\_\_\_\_

(Females Only) Are You Pregnant? Y N Date of Last Menstrual Period \_\_\_\_\_

Do you have children? Y N Age(s) \_\_\_\_\_

Personal Medical History: (Please Circle the Following Relevant to Your Medical History)

Cancer	Muscular Dystrophy	Rheumatic Fever	Digestive Disorders	Tuberculosis	Convulsions
Polio	Multiple Sclerosis	Scarlet Fever	Sinus Trouble	Concussion	Backaches
Diabetes	Nervousness	Numbness	Heart Trouble	Hepatitis	Dizziness
Asthma	Venereal Disease	High Cholesterol	High Blood Pressure	HIV	Hepatitis C

Do You Have Insurance? Y N Primary? Y N Secondary? Y N

Name of Insurance \_\_\_\_\_ Primary Policy Holder: Self / Spouse / Parent / Other

Name of Primary Policy Holder \_\_\_\_\_ Primary's Date of Birth: \_\_\_\_\_  
(If spouse / parent / other)

Insurance ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

I understand and agree that health and insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account, however, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if North Star Chiropractic Center extends credit to me and I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made. I hereby authorize North Star Chiropractic Center, and whomever he/she may designate as his/her assistants, to administer treatment as he/she deems necessary and I also authorize the release of any information required in the course of my examination or treatment. I certify that the above is true and correct.

Patient's (Parent or Guardian's) Signature \_\_\_\_\_

# PAIN DRAWING

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

Attending Doctor \_\_\_\_\_

Using the letters below, mark the areas on your body where you feel the described sensations. Include all affected areas.  
Please complete the picture by drawing your face. ☺

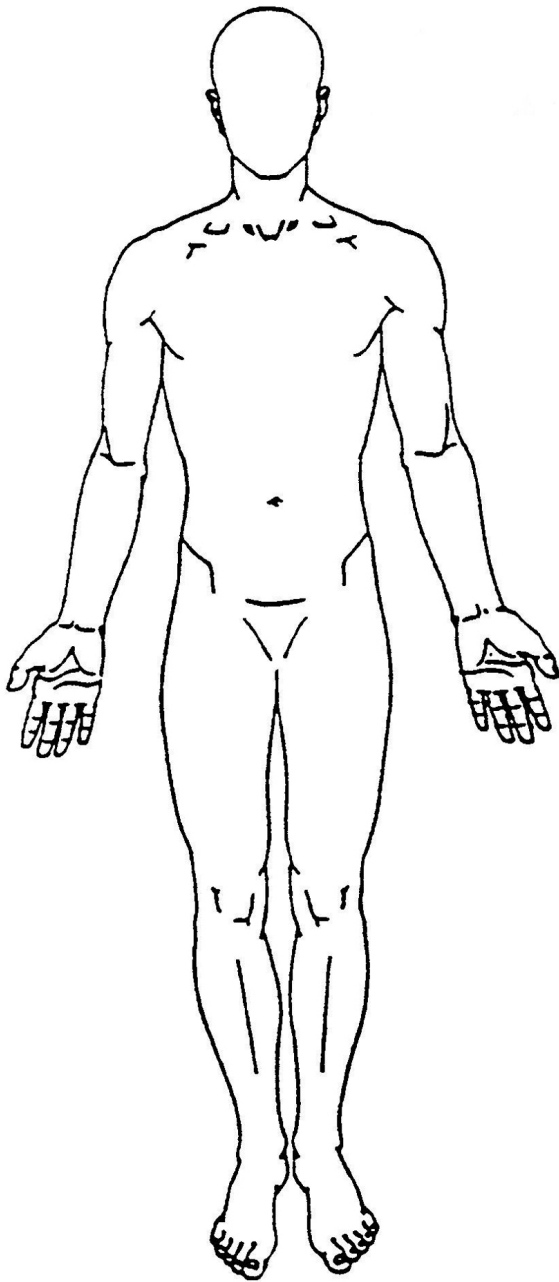
**A** = Ache

**B** = Burning

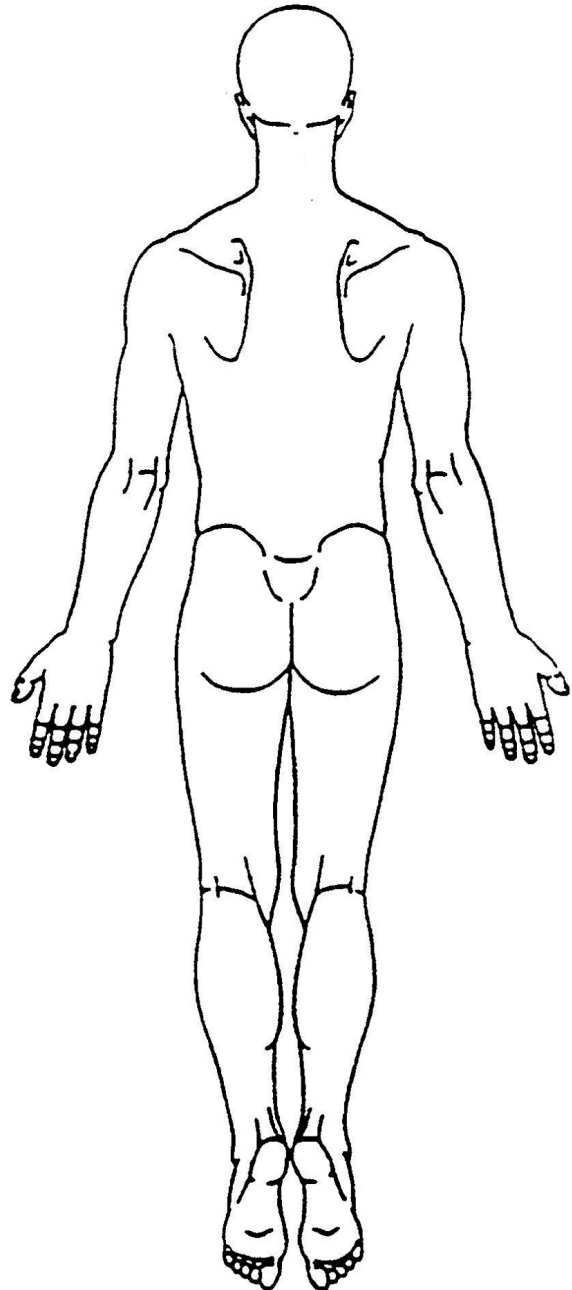
**N** = Numbness

**P** = Pins & Needles

**S** = Stabbing



**FRONT**



**BACK**

Patient Signature \_\_\_\_\_



## North Star Chiropractic Center

### Acknowledgement of Receipt of Notice of Privacy Practices

North Star Chiropractic Center is concerned about the privacy of our patients' health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. HIPAA requires a chiropractic practice to make a good faith effort to obtain a signed acknowledgement from the patient prior to releasing any medical information.

I acknowledge that North Star Chiropractic Center staff has explained to me the Privacy Practices of their office. I understand that I have a right to receive and review a copy of the Privacy Practices Notice if I request it.

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**OR**

\_\_\_\_\_  
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

- ☐ Parent
- ☐ Guardian
- ☐ Power of Attorney
- ☐ Other \_\_\_\_\_



## North Star Chiropractic Center

### *BILLING & COLLECTION POLICIES FOR AUTOMOBILE COLLISIONS*

I understand that for treatment provided by North Star Chiropractic Center related to an automobile collision, primary first party insurance is with the Personal Injury Protection (PIP) Insurance for the vehicle I was driving, riding in as a passenger, or struck by as a pedestrian/bicyclist. I understand and authorize North Star Chiropractic Center to bill PIP and authorize the release of any information acquired in the course of my examination and treatment in accordance with HIPAA privacy regulations.

Date of automobile collision: \_\_\_\_\_

My car insurance company is: \_\_\_\_\_

My car insurance claim number is: \_\_\_\_\_

The adjuster handling my claim is: \_\_\_\_\_

My adjuster's phone number is: \_\_\_\_\_

Should PIP insurance not be available, exhaust, or terminate for any reason, I authorize North Star Chiropractic Center to bill any applicable health insurance I may have available, subject to any contract North Star Chiropractic Center may have with such carrier, and authorize the release of any information acquired in the course of my examination and treatment in accordance with HIPAA privacy regulations. I understand that my health insurance may require me to complete an Accident and Sickness Questionnaire in order to process my claims related to an automobile collision, and agree to complete it in a timely manner if my insurance company requests it from me. I will be responsible for paying any applicable deductibles, coinsurance, or copays.

My personal health insurance company is: \_\_\_\_\_

My health insurance ID number is: \_\_\_\_\_

I authorize North Star Chiropractic Center to file a medical lien against any applicable third-party insurance settlement pursuant to RCW 60.44.010, et seq. I understand and acknowledge that payment of any medical lien, in some circumstances, may not fully pay my outstanding final charges due to North Star Chiropractic Center for treatment provided, and I may be required to make additional payments after satisfaction of the lien.

The third-party insurance company is: \_\_\_\_\_

The third-party insurance claim number is: \_\_\_\_\_

The adjuster handling my third-party claim is: \_\_\_\_\_

The third-party adjuster's phone number is: \_\_\_\_\_

I understand that North Star Chiropractic Center will agree to await payment for services rendered until my treatment has concluded and I have settled with the third-party provided I have hired an attorney to assist with my claim and they have signed a Letter of Protection agreeing to remit payment directly to North Star Chiropractic Center out of my settlement. I further understand that my settlement may not fully pay my outstanding final charges due for treatment provided, and I may be required to make additional payments.

My attorney is: \_\_\_\_\_

My attorney's phone number is: \_\_\_\_\_

I, \_\_\_\_\_, have read the Policies and will honor them,

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**North Star Chiropractic Center**  
**PERSONAL INJURY HISTORY FORM: AUTO COLLISION**

**Instructions: Please carefully consider and answer each question as completely as possible.**

Name: \_\_\_\_\_ Today's Date: (\_\_\_\_ / \_\_\_\_ / \_\_\_\_) Date of Collision: (\_\_\_\_ / \_\_\_\_ / \_\_\_\_)

For this auto collision, were you the: ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Bicyclist

Was the impact to you or your vehicle from: ☐ Behind ☐ Right side ☐ Left side ☐ Front ☐ Vehicle was parked  
☐ Other (please explain) \_\_\_\_\_

Did your vehicle strike other(s) involved? ☐ Yes ☐ No Did another vehicle(s) strike yours? ☐ Yes ☐ No

Were traffic tickets issued? ☐ Yes ☐ No If yes, to ☐ You ☐ The other driver ☐ The driver of your car

Did any part of your body strike any part of the vehicle? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_

Did you have a safety belt on? ☐ Yes ☐ No Shoulder strap? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No Headrest height or position? ☐ Shoulder ☐ Neck ☐ Head ☐ Above

Did you lose consciousness? ☐ Yes ☐ No If yes, how long? \_\_\_\_\_

Were you stunned (disoriented/confused/in a state of shock)? ☐ Yes ☐ No How long? \_\_\_\_\_

Did you feel or hear popping, tearing, or ripping noise in your neck or back? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_

Did you feel any pain? ☐ Yes ☐ No If yes, where? \_\_\_\_\_

How long after the collision? \_\_\_\_\_

Did you find any bruises? ☐ Yes ☐ No If yes, where? \_\_\_\_\_

**Instructions: Please check symptoms you have experienced since the collision:**

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Headache                   | <input type="checkbox"/> Mid Back Pain            | <input type="checkbox"/> Dizziness                  | <input type="checkbox"/> Excessive Perspiration |
| <input type="checkbox"/> Skull or Head Pain         | <input type="checkbox"/> Mid Back Stiffness       | <input type="checkbox"/> Fainting                   | <input type="checkbox"/> Loss of Perspiration   |
| <input type="checkbox"/> Neck Pain                  | <input type="checkbox"/> Low Back Pain            | <input type="checkbox"/> Eye Strain                 | <input type="checkbox"/> Cold Sweats            |
| <input type="checkbox"/> Neck Stiffness             | <input type="checkbox"/> Low Back Stiffness       | <input type="checkbox"/> Difficulty Focusing        | <input type="checkbox"/> Fever                  |
| <input type="checkbox"/> Head Feels too Heavy       | <input type="checkbox"/> Rib Pain                 | <input type="checkbox"/> Pain Behind the Eyes       | <input type="checkbox"/> Swelling               |
| <input type="checkbox"/> Shoulder Pain              | <input type="checkbox"/> Hip Pain                 | <input type="checkbox"/> Eyes Sensitive to Light    | <input type="checkbox"/> Depression             |
| <input type="checkbox"/> Shoulder Stiffness         | <input type="checkbox"/> Buttock Pain             | <input type="checkbox"/> Double Vision              | <input type="checkbox"/> Anxiety                |
| <input type="checkbox"/> Arm Pain                   | <input type="checkbox"/> Leg Pain                 | <input type="checkbox"/> Buzzing or Ringing in Ears | <input type="checkbox"/> Tension                |
| <input type="checkbox"/> Arm Numbness               | <input type="checkbox"/> Leg Numbness             | <input type="checkbox"/> Loss of Balance            | <input type="checkbox"/> Irritability           |
| <input type="checkbox"/> Pins and Needles in Arms   | <input type="checkbox"/> Pins and Needles in Legs | <input type="checkbox"/> Palpitations               | <input type="checkbox"/> Nervousness            |
| <input type="checkbox"/> Numbness in Hands/ Fingers | <input type="checkbox"/> Numbness in Feet/Toes    | <input type="checkbox"/> Shortness of Breath        | <input type="checkbox"/> Mental Dullness        |
| <input type="checkbox"/> Cold Hands                 | <input type="checkbox"/> Cold Feet                | <input type="checkbox"/> Difficulty Rising to Walk  | <input type="checkbox"/> Loss of Memory         |
| <input type="checkbox"/> Upper Back Pain            | <input type="checkbox"/> Sinus Trouble            | <input type="checkbox"/> Painful Breathing          | <input type="checkbox"/> Difficulty Sleeping    |
| <input type="checkbox"/> Upper Back Stiffness       | <input type="checkbox"/> Loss of Smell            | <input type="checkbox"/> Tremors                    | <input type="checkbox"/> Fatigue                |
| <input type="checkbox"/> Chest Pain                 | <input type="checkbox"/> Loss of Color            | <input type="checkbox"/> Loss of Taste              | <input type="checkbox"/> Face Flushed           |

**Instructions: Please check the degree of difficulty you have experienced in daily living:**

Riding in car:

☐ Light ☐ Moderate ☐ Excessive ☐ Unable

Bending:

☐ Light ☐ Moderate ☐ Excessive ☐ Unable

Standing:

☐ Light ☐ Moderate ☐ Excessive ☐ Unable

Twisting/Turning:

☐ Light ☐ Moderate ☐ Excessive ☐ Unable

Sitting:

☐ Light ☐ Moderate ☐ Excessive ☐ Unable

Walking:

☐ Light ☐ Moderate ☐ Excessive ☐ Unable

Lifting:

☐ Light ☐ Moderate ☐ Excessive ☐ Unable

Other: \_\_\_\_\_

☐ Light ☐ Moderate ☐ Excessive ☐ Unable

# NORTH STAR CHIROPRACTIC CENTER

## *Letter of Protection*

*Dr. Paul Early, DC – North Star Chiropractic Center – 820 NE Northgate Way Seattle, WA 98125 – (206) 440-7700*

I do hereby authorize North Star Chiropractic Center to furnish you, my attorney, with a full report of their examination, diagnosis, treatment in regards to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing them for medical services rendered to me both by reason of this accident and by reason of any other bills that are due to this office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which pay be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by them for services rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration of them waiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning the signed letter to the doctor's office. I have been advised that if you, my attorney, do not wish to cooperate in protecting the doctor's interest, they will not await payment, but require me to make payments on a current basis.

Dated: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms above, and agrees to withhold such sums from any settlement, judgment or verdict, obtained by the lawyer for their client, as may be necessary to adequately protect said doctor named above.

Dated: \_\_\_\_\_

Attorney's Name: \_\_\_\_\_

Attorney's Signature: \_\_\_\_\_

Attorney's Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_