NORTH STAR
CHIROPRACTIC
CENTER

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

INFORMED CONSENT FOR CARE

Please read and initial each section

__ The nature of the chiropractic adjustment.

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way *as* to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

__ Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, I am consenting to the following procedures:

spinal manipulative therapy	radiographic studies	orthopedic testing	postural analysis testing
range of motion testing	intersegmental traction	vital signs	
muscle strength testing	lumbar traction	basic neurological testing	
hot/cold therapy	palpation	exercises	

__ The risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make eve1y reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

__ The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and x-ray. Stroke and /or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most common research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

__ The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and painkillers
- Hospitalization
- Surgery
- If you chose to use one of the above noted "other treatment" options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

__ The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

“Open adjusting” environment used.

It is the practice of this office to provide chiropractic care in an “open adjusting’ environment. “Open adjusting” involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another, and some ongoing routine details of care are discussed within earshot of other patients and staff. The environment is used for ongoing care and is not the environment used for taking patient histories, performing examinations, or presenting reports of findings. These procedures are completed in the doctor’s private office. If you choose not to be adjusted with another patient sharing the open adjusting environment, other arrangements will be made for you.

PLEASE READ AND SIGN BELOW

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Early and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____

Patient Name (print)

_____ _____

Patient Signature Date

OR

I authorize the doctor of North Star Chiropractic to administer such procedures and treatment to my **minor child** named above as necessary. I certify that have authority and responsibility to authorize treatment for this child.

_____ _____

Signature of Parent/Guardian of a minor 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 _____

What Brought You to See Us Today? _____

Have You Been Treated by a Physician for Any Health Conditions 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 Personal Health 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 _____

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_____

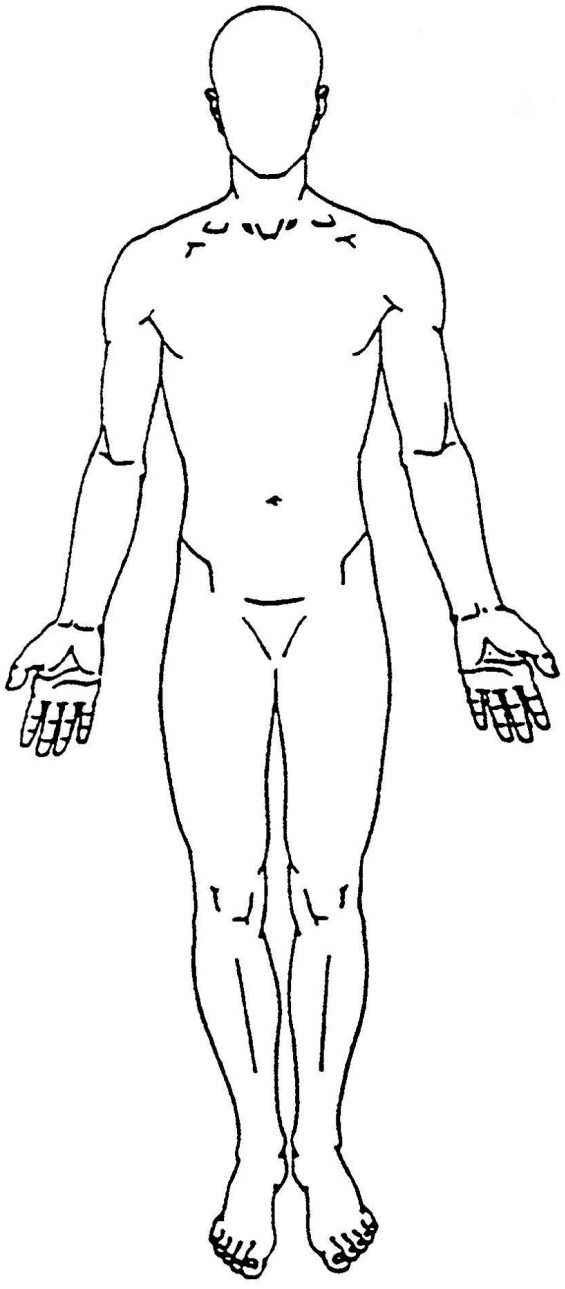
PAIN DRAWING

Patient Name_____ **Date**_____

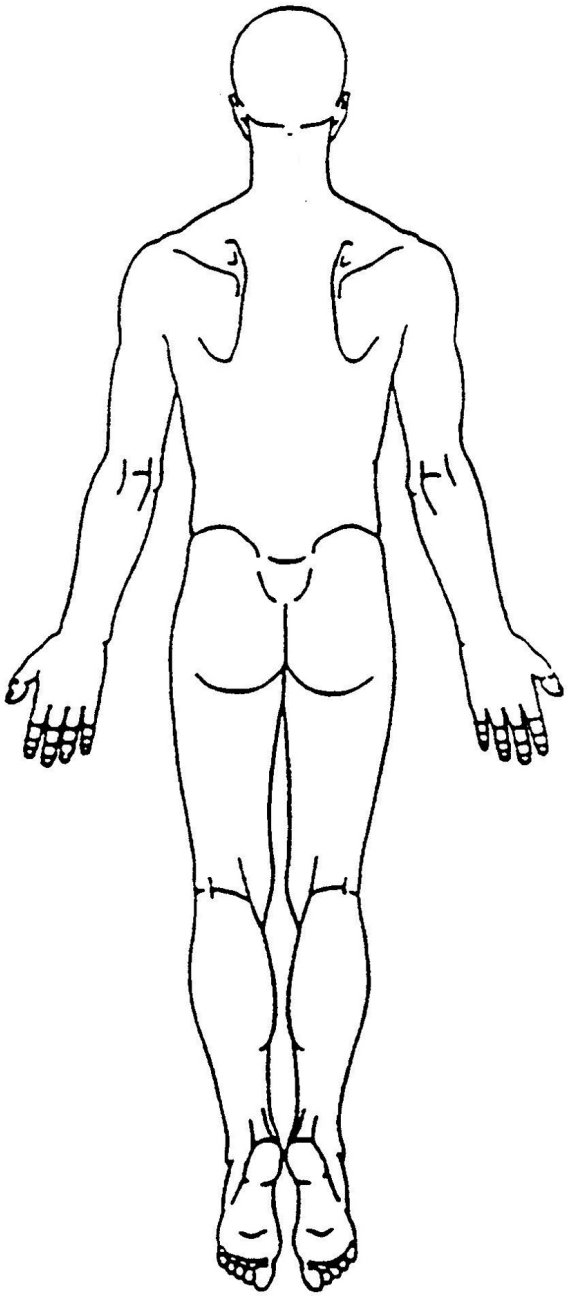
Attending Doctor_____

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

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:

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

This form is used to request copies of medical records and radiology pictures. Only patients or their legal representatives (with ID verification) may make a medical records request. Please print legibly.

I. Patient Information

Patient Name: _____Date of Birth: _____

Full Address: _____

Phone Number: _____Social Security #: _____

II. Protected Health Information that is to be released:

Information to be released for the date(s) of service from (date)_____ to (date) _____

(Sending any medical information via email may not be HIPAA compliant)

☐ Complete Health Record	☐ Discharge Summary	☐ Clinic/Outpatient Visit
☐ History/Physical Records	☐ Consultation Reports	☐ Progress Notes
☐ MRI Report / Disc of: _____	☐ Operative/Procedure Reports	☐ Radiology Digital Pictures/ Physical Films
☐ Laboratory Reports	☐ ER Reports	☐ Psychiatric Records
☐ Other: _____		☐ Billing (Claim Information)

III. Facility/Person to Release Records

☐ **North Star Chiropractic Center**
Phone Number: (206) 440-7700
Fax Number: (206) 440-8900
Address: 820 NE Northgate Way
Seattle WA 98125

☐ Doctor, Hospital, Attorney, Insurance Company

Name: _____
Phone Number: _____
Fax Number: _____
Address: _____

IV. Preferred Format:

☐ Fax ☐ Mail ☐ In Person ☐ Email ☐ CD

V. Recipient of Records:

☐ The above-mentioned patient

☐ **North Star Chiropractic Center**
Phone Number: (206) 440-7700
Fax Number: (206) 440-8900
Address: 820 NE Northgate Way
Seattle WA 98125

☐ Doctor, Hospital, Attorney, Insurance Company

Name: _____
Phone Number: _____
Fax Number: _____
Address: _____

VI. Terms of Authorization:

I, the undersigned, authorize the release of, or request access to the medical information specified above f the medical record(s) of the above name patient.

I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken thereon. This authorization will expire 90 days from the date of authorization.

Access to medical information is the right of every patient; duplication and distribution is a service. Releases are subject to copy and distribution cost. I understand the potentiality of charge for the service and release of medical information and accept financial responsibility.

_____ _____/_____/_____

Signature of Patient or Legally Authorized Representative: **Date:**

_____ _____

Printed Name of Patient or Legally Authorized Representative: **Relationship to Patient:**

North Star Chiropractic Center

MASSAGE THERAPY PATIENT INFORMATION

Name_____ Date_____

Is your treatment due to (please circle): None | Worker's Compensation (L&I) Claim | Motor Vehicle Collision Claim

If you have been involved in an accident, please provide a brief description of what happened:

_____

_____

The majority of your pain is located: _____

Please circle the number of any of the following health concerns:

1. Headaches/Migraines
2. Neck Pain
3. Pain between Shoulder Blades
4. Tension across Top of Shoulders
5. Shoulder or Arm Pain
6. Wrist/Hand Pain
7. Tingling/Numbness in Arms or Hands
8. Carpal Tunnel
9. Mid-Back Pain
10. Low-Back Pain
11. Sciatic Pain
12. Leg or Hip Pain
13. Ankle/Foot Pain
14. Tingling/Numbness in Legs or Feet
15. Dizziness
16. Problem Sleeping
17. Low Energy/Fatigued
18. Other_____

Which of these have you experienced for the longest time?_____

To answer the questions below, please use the following scale to rate your pain:
0 = No Pain; 5 = Moderate Pain; 10 = Worst Possible Pain

With no activity my pain intensity is	0 1 2 3 4 5 6 7 8 9 10	Is it constant? Y N	
When I lift	0 1 2 3 4 5 6 7 8 9 10	When I dress	0 1 2 3 4 5 6 7 8 9 10
When I read	0 1 2 3 4 5 6 7 8 9 10	When I walk	0 1 2 3 4 5 6 7 8 9 10
When I work	0 1 2 3 4 5 6 7 8 9 10	When I sit	0 1 2 3 4 5 6 7 8 9 10
When I drive	0 1 2 3 4 5 6 7 8 9 10	When I stand	0 1 2 3 4 5 6 7 8 9 10
When I sleep	0 1 2 3 4 5 6 7 8 9 10	When I type	0 1 2 3 4 5 6 7 8 9 10

Massage service preferences (please circle):

1. Do you prefer soft music during your massage?

   Y N No Preference

2. Level of communication with the Massage Therapist:

   Light conversation Moderate conversation No preference

Patient's (Parent or Guardian's) Signature _____

If you are unable to keep your appointment, please provide 24 hours' notice

Patient notice: All referred massage treatments covered by your insurance are subject to medical necessity based on the expertise of the Licensed Massage Therapist. This may or may not include the treatment of a specific area of the body during the entirety of the massage and does not guarantee full body treatment. It is out of the scope of the Massage Therapist's license to diagnose or determine treatment frequency.