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 Center

CONFIDENTIAL PATIENT INFORMATION

Date_____ Name_____ Sex_____ Marital Status_____ DOB_____ Age_____

Address_____ City_____ State_____ Zip_____

Social Security_____ Email_____

Home Phone_____ Cell Phone_____ Work Phone_____

Occupation_____ Company Name_____ Location_____

Spouse Name _____ Children Name/Age_____

Emergency Contact (Not Spouse)_____ Phone Number_____

Who Referred You to This Clinic_____

Is Your Visit Due to an Accident? Y N (if yes, please see receptionist for injury report)

Your Present Complaint_____

Briefly Describe Your Symptoms_____

Describe Any Operations You've Had & Dates _____

_____

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_____

Are You Pregnant? Y N Date of Last Menstrual Period _____

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 Company_____ ID Number_____

Group Number_____ Primary Holder_____ DOB_____

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 _____

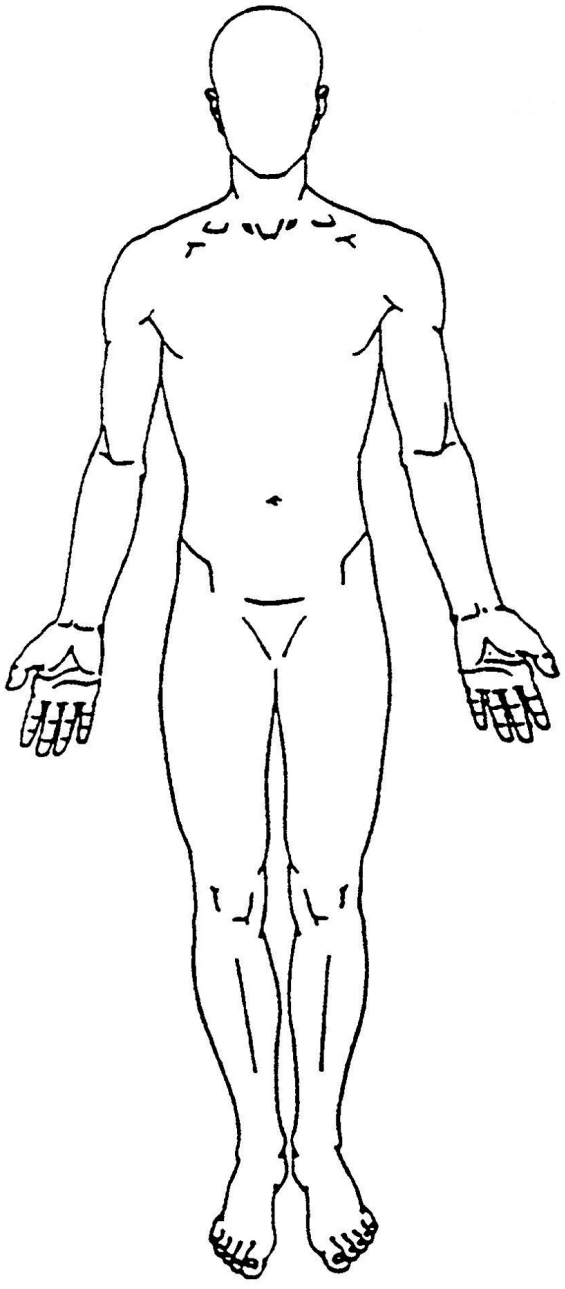
PAIN DRAWING

Patient Name_____ **Date**_____

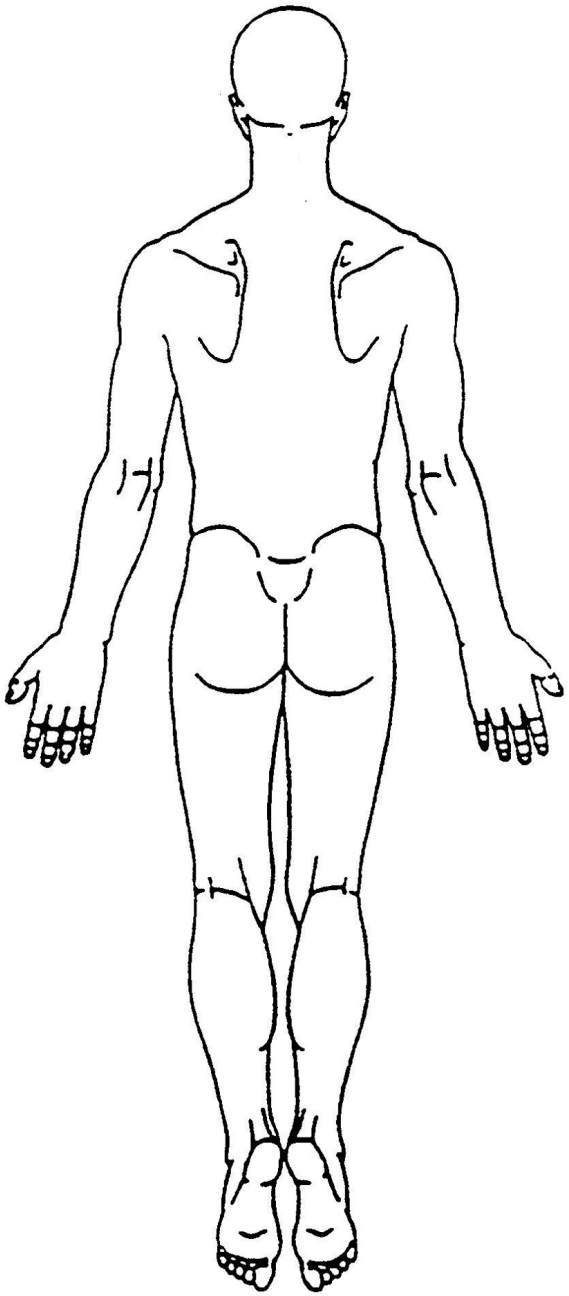
Attending Doctor_____

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

PERSONAL INJURY HISTORY FORM

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

Name: _____ Today's Date: (____/____/____) Date of Injury: (____/____/____)

Describe how your injury occurred: _____

_____

_____

Choose factor/s which directly or indirectly caused the injury to occur (please select all that apply):

❑ Struck by Flying/Thrown Object ❑ Struck by an Object/Person ❑ Faulty Equipment ❑ A Fall

❑ Caught In/Under/Between Objects ❑ Struck Against Object ❑ Fluid Exposure ❑ Other

Did you lose consciousness? ❑ Yes ❑ No If yes, please explain: _____

_____

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 injury? _____

Did you find any bruises? ❑ Yes ❑ No If yes, where? _____

Instructions: Please check symptoms you have experienced since the injury:

❑ Headache
❑ Skull or Head Pain
❑ Neck Pain
❑ Neck Stiffness
❑ Head Feels too Heavy
❑ Shoulder Pain
❑ Shoulder Stiffness
❑ Arm Pain
❑ Arm Numbness
❑ Pins and Needles in Arms
❑ Numbness in Hands/ Fingers
❑ Cold Hands
❑ Upper Back Pain
❑ Upper Back Stiffness
❑ Chest Pain

❑ Mid Back Pain
❑ Mid Back Stiffness
❑ Low Back Pain
❑ Low Back Stiffness
❑ Rib Pain
❑ Hip Pain
❑ Buttock Pain
❑ Leg Pain
❑ Leg Numbness
❑ Pins and Needles in Legs
❑ Numbness in Feet/Toes
❑ Cold Feet
❑ Sinus Trouble
❑ Loss of Smell
❑ Loss of Color

❑ Dizziness
❑ Fainting
❑ Eye Strain
❑ Difficulty Focusing
❑ Pain Behind the Eyes
❑ Eyes Sensitive to Light
❑ Double Vision
❑ Buzzing or Ringing in Ears
❑ Loss of Balance
❑ Palpitations
❑ Shortness of Breath
❑ Difficulty Rising to Walk
❑ Painful Breathing
❑ Tremors
❑ Loss of Taste

❑ Excessive Perspiration
❑ Loss of Perspiration
❑ Cold Sweats
❑ Fever
❑ Swelling
❑ Depression
❑ Anxiety
❑ Tension
❑ Irritability
❑ Nervousness
❑ Mental Dullness
❑ Loss of Memory
❑ Difficulty Sleeping
❑ Fatigue
❑ 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: _____

_____

_____

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 at the time that it provides the HIPAA Notice of Privacy Practices to the patient.

I acknowledge that North Star Chiropractic Center staff provided me with a copy of their Privacy Practices Notice to review. I understand that I have a right to receive a copy of this 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_____