All Ways Chiropractic
Dr. Michael Eekhoff, B.A., D.C.
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Ph: (360) 352-8896 - Fax: (360) 705-0633 - www.AllWaysChiro.com

About You

Today's Date:_____

Legal Name:_____

Preferred Name:

Sex: Male ❒ Female ❒

Date of Birth: ____/____/____

Social Security Number (optional):_____

Marital Status: Married ❒ Single ❒ Divorced ❒ Separated ❒ Widow(er) ❒

Preferred Contact # ❒ Home ❒ Cell ❒ Work ❒ Other
Home #_____ Cell #_____

Work #_____ Other #_____

Mailing Address_____

City_____ State_____ Zip Code_____

Email _____

****We will not sell your e-mail for patient communication purposes – It is for internal purposes only.**

Referred by:_____

Patient's Occupation: _____ Employer: _____

Emergency Contact_____ Relationship_____

Phone #_____ ❒ Home ❒ Cell ❒ Work

INSURANCE INFORMATION

Primary Insurance

Insured Name:_____ Date of Birth_____

Male ❒ Female ❒ Relationship to Patient: _____

Insured Address: _____

Secondary Insurance

Insured Name:_____ Date of Birth_____

Male ❒ Female ❒ Relationship to Patient: _____

Insured Address: _____

All Ways Chiropractic, PLLC

Please draw the location of your symptoms on the body diagram below and mark your current level of pain on the line at the bottom of the diagram.

Dull / Ache
^ ^ ^ ^

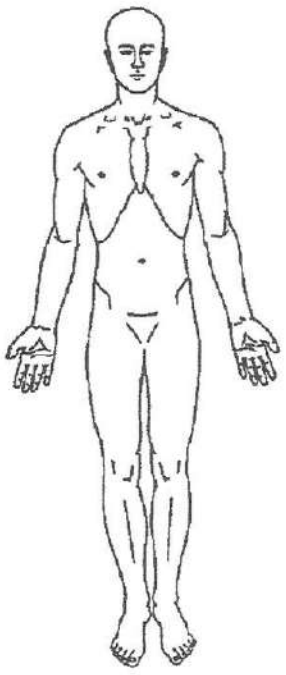
Burning
= = = = =

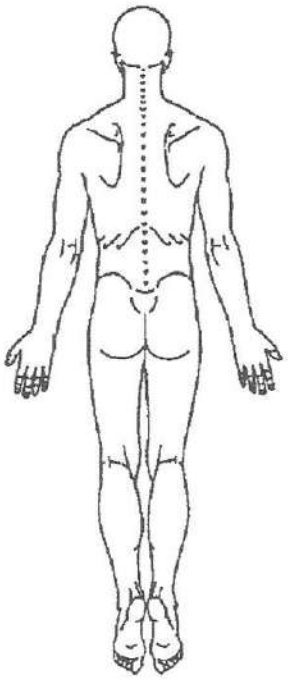
Numbness
o o o o o

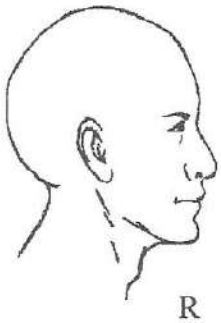
Pins & Needles
. . . . . .

Sharp
x x x x x x

Other
/ / / / / /







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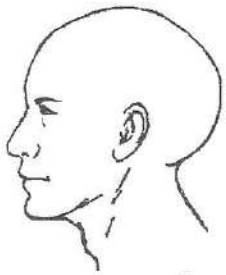


L

No Pain ---------- Worst Pain Possible

Please make a slash through this line as to the level of your pain.

Is the pain getting worse_____ staying the same_____ or improving _____?

Is the pain occasional _____ frequent _____ or constant _____?

What makes the pain better?_____

What makes the pain worse?_____

Patient's Name: _____

Patient's Signature: _____

Date Signed: _____

Personal Injury Patient History

History of Occurrence

Date of accident_____ Time:_____ ❒am ❒pm

1. Where were you seated? ❒ Driver ❒ Passenger
2. Year, Make & Model of your car:_____Other Car:_____
3. Road condition at time of collision: ❒ Icy ❒ Rainy & Wet ❒ Clear ❒ Dark
4. Your car: ❒ Hit another car in the: ❒ Was hit in the: ❒ Right ❒ Left ❒ Rear ❒ Front ❒ Hit object:
5. Were the police on-scene? ❒ Yes ❒ No If yes, was a report made? ❒ Yes ❒ No
6. Were EMS services on-scene? ❒ Yes ❒ No
7. Were tow truck services used? ❒ Yes ❒ No If Yes, was it your vehicle towed? ❒ Yes ❒ No

Impact / Seat Belt / Headrest / Speed

8. Describe in your own words what happened **to you** upon impact: _____
   _____
9. Did you see that the collision was about to happen? ❒ Yes ❒ No
10. Were seat belts/shoulder harness worn? ❒ Yes ❒ No
11. Were you wearing a hat or glasses? ❒ Yes ❒ No If yes, still on after collision? ❒ Yes ❒ No
12. Did air bag deploy? ❒ Yes ❒ No If yes, were you struck? ❒ Yes ❒ No
13. Does your car have headrests? ❒ Yes ❒ No
    If yes, what was the position of those headrests compared to your head before the collision?
    ❒ Top of headrest even with **bottom** of head ❒ Top of headrest even with **top** of head
    ❒ Top of headrest even with **middle** of neck
14. Was your foot on the brake? ❒ Yes ❒ No
15. Do you have foot / Ankle pain? ❒ Yes ❒ No
16. Was your car moving at the time of collision? ❒ Yes ❒ No
17. If yes, how fast would you estimate you were going? _____m.p.h. (estimate)
18. How fast was the other car traveling? _____m.p.h. (estimate)

Head / Body Position / Able to Move Body

19. Head/Body position at time of impact:
    ❒ **Head Turned:** ❒ Right ❒ Left ❒ Looking back ❒ Not turned/straight
    ❒ **Body Rotated:** ❒ Right ❒ Left ❒ Straight
20. At the time of collision, recall what parts of your **head** or **body** hit what parts on the inside of your car:
    _____
21. As a result of the collision, you were: ❒ Rendered unconscious ❒ Dazed, circumstances vague
22. Could you move all parts of your body?: ❒ Yes ❒ No
    If no, what parts could you not move and why?_____
23. Were you able to get out of the car and walk unaided? ❒ Yes ❒ No
    If no, why_____

First Doctor / Hospital / Clinic Seen

24. Did you go seek medical help immediately / soon after the collision? ❒ Yes ❒ No
    If yes, how did you get there? ❒Someone else drove me ❒ Drove my own car ❒ Ambulance ❒ Police
25. Have you seen a physician / practitioner for the collision? ❒ Yes ❒ No
26. If yes, who?_____
27. Were X-Rays taken ❒ Yes ❒ No
28. Were you given a: ❒ Cervical Collar ❒ Ice ❒ None
29. Were you given medication? ❒ Yes ❒ No
    If yes, what?_____
30. Were you given treatment? ❒ Yes ❒ No
    If yes, what treatment was given to you?_____
    What benefits did you receive from the treatment?_____
    Date of last treatment:_____

Symptoms From Accident

31. Did you get bruises or bleeding cuts as a result of the collision? ❒ Yes ❒ No
    If yes, describe:_____
32. Please describe how you felt: **(Please Be Specific)**
    Immediately after collision:_____
    Later that day and night:_____
    The next day(s):_____
33. Check symptoms apparent **since** the collision:

☐ Headache	☐ Numb toes	☐ Stiffness
☐ Fainting	☐ Numb Fingers	☐ Tension
☐ Cold Hands	☐ Shortness of breath	☐ Loss of balance
☐ Cold Feet	☐ Depression	☐ Anxiousness
☐ Cold Sweats	☐ Sleeping problems	☐ Irritability
☐ Dizziness	☐ Chest Pain	☐ Mid-back pain
☐ Fatigue	☐ Nervousness	☐ Loss of smell
☐ Blurred Vision	☐ Constipation	☐ Loss of taste
☐ Eyes sensitive to light	☐ Diarrhea	☐ Low back pain
☐ Pain behind eyes	☐ Neck Pain/	☐ Ringing in ears
☐ Loss of memory		☐ Other: _____

Prior Similar Symptoms

34. Did you have any physical complaints **just before the collision?** ❒ Yes ❒ No
    If yes, describe:_____
35. **Prior** to this collision, have you **ever** had symptoms similar to what you are experiencing now?
    ❒ Yes ❒ No
    If yes, please explain (briefly include past falls, injuries, collisions, operations, etc.):
    _____
36. Are these symptoms worse since the collision? ❒ Yes ❒ No

Activities of Daily Living

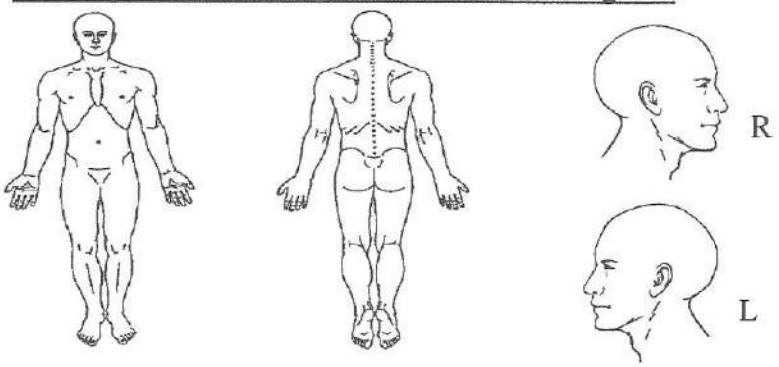
37. Do you notice any of your home activities that are different now than from before the collision? ❒ Yes ❒ No If yes, please list them: _____
38. The activities that are now painful to do are: _____

Medical History

39. Have you had any previous surgeries? ❒ Yes ❒ No
    If yes, when? _____ For what? _____
40. Have you had any previous motor vehicle accidents? ❒ Yes ❒ No
    If yes, when? _____ Did you receive treatment? _____

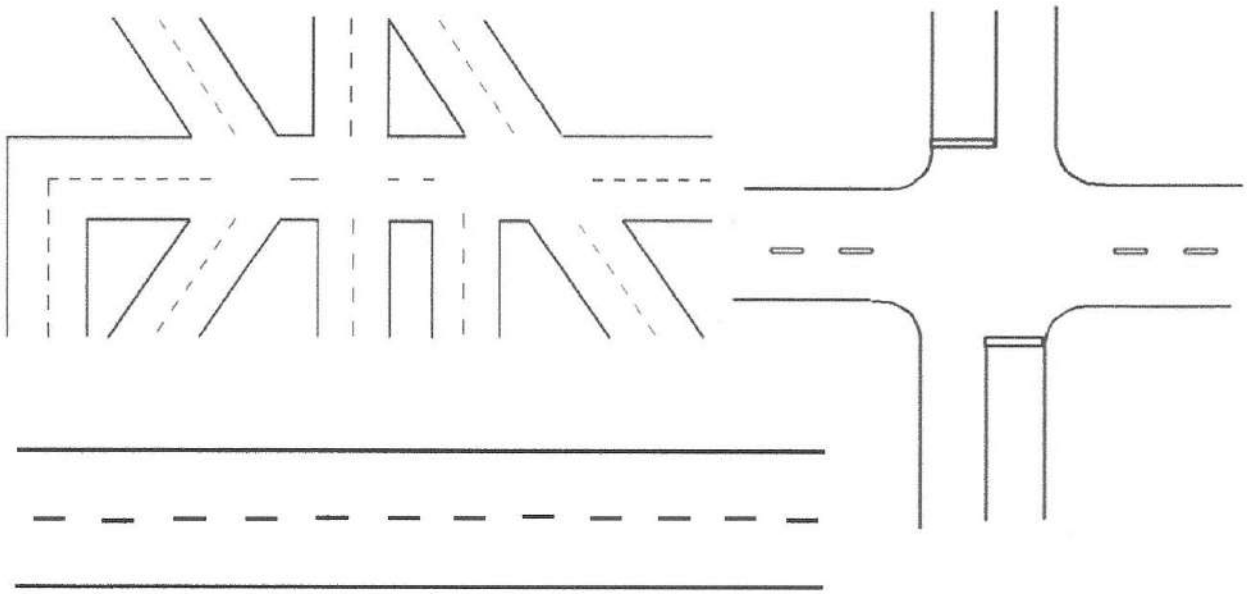
Please draw the location of your symptoms on the body diagram below and mark your current level of pain on the line at the bottom of the diagram.

Dull/Ache: ^^^
Burning: ===
Numbness: OOO
Pins & Needles: * * * *
Sharp: XXXX
Other: /////



Least Painful ⟷ Most Painful

Indicate on one of these diagrams how the collision happened
(Note the car you were in as car "A")



Insurance Information
AUTOMOBILE COLLISION

YOUR PERSONAL CAR INSURANCE INFORMATION

Is there an Open Personal Injury Protection (PIP) claim on file with YOUR insurance company?
❒ Yes ❒ No

If NO, please explain why:_____

Company Name:_____ Claim #_____

Address:_____ City:_____ State:_____ Zip:_____

Claim Adjuster's Name:_____ Phone:_____

OTHER VEHICLE'S INSURANCE INFORMATION

Company Name:_____ Claim #_____

Address:_____ City:_____ State:_____ Zip:_____

Claim Adjuster's Name:_____ Phone #:_____

ATTORNEY ON CASE

Do you have an attorney on this case? ❒ Yes ❒ No

If yes:

Name:_____ Phone:_____

Address:_____ City:_____ State:_____ Zip:_____

Patient Signature:_____ Date:_____

Neck Index

Form N1-100

rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

~~Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100~~

Neck Index Score

Back Index

Form BI100

rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____

All Ways Chiropractic - ***Health History***

Patient Name:_____ Date:_____

Primary Care Physician:_____ Date Last Seen:_____

Are you pregnant? ❒ Yes ❒ No Due Date:_____ # of Children:_____ # of Pregnancies:_____

Smoking Status: ❒ Every day ❒ Occasional ❒ Former Smoker ❒ Never smoked

How often do you consume alcohol? ❒Never ❒1-2 times per week ❒3-4 times per week ❒5+ times per week

How often do you consume caffeine? ❒Never ❒1-2 times per week ❒3-4 times per week ❒5+ times per week

How often do you exercise? ❒Never ❒1-2 times per week ❒3-4 times per week ❒5+ times per week

Health History: - CIRCLE ALL that APPLY. CHECK NONE if NONE APPLY

SURGICAL HISTORY ❒ ***NONE***	***MEDICATIONS*** ❒ ***NONE*** *OTC = Over the Counter RX = Prescription*	***PERSONAL & FAMILY HEALTH HISTORY*** ❒ ***NONE*** ❒ ***OTHER***
Spinal Fusion	Muscle Relaxer ❒ OTC ❒ RX	Cancer Self Family
Discectomy	NSAID/Ibuprofen ❒OTC ❒ RX	AIDS/HIV Self Family
Laminectomy	Tylenol ❒ OTC ❒ RX	Alcoholism Self Family
Abdominal Aortic Aneurysm Repair	Pain Reliever/Pain Killer ❒ OTC ❒ RX	Alzheimer's Self Family
Appendectomy	Antacid ❒ OTC ❒ RX	Anemia Self Family
Breast Augmentation	Anti-Depressant ❒ OTC ❒ RX	Arthritis Self Family
Bunionectomy - Left Side	Anti-Viral ❒ OTC ❒ RX	Asthma Self Family
Bunionectomy – Right Side	Aspirin ❒ OTC ❒ RX	Bleeding Disorders Self Family
Cardiac Bypass	Birth Control ❒ OTC ❒ RX	Bronchitis Self Family
Cardiac Valve Replacement	Blood Pressure ❒ OTC ❒ RX	Chemical Dependency Self Family
Cataract	Chemotherapy ❒ OTC ❒ RX	Depression Self Family
C-Section	Codeine ❒ OTC ❒ RX	Diabetes Self Family
Cosmetic	Hallucinogenic ❒ OTC ❒ RX	Eating Disorder Self Family
Carpal Tunnel Syndrome – Left Hand	Marijuana ❒ OTC ❒ RX	Emphysema Self Family
Carpal Tunnel Syndrome – Right Hand	Mood Elevator ❒ OTC ❒ RX	Epilepsy Self Family
Ear Tubes	Sleeping Pill ❒ OTC ❒ RX	Fractures Self Family
Gall Bladder Removed	Stimulant ❒ OTC ❒ RX	Heart Disease Self Family
Ganglion Cyst	Tranquilizer ❒ OTC ❒ RX	Hepatitis Self Family
Gastric Bypass	Other ❒	Hernia Self Family
Hysterectomy Complete	***ACCIDENT(S) HISTORY*** ❒ ***NONE***	Herniated Disc Self Family
Hysterectomy Partial	Auto Accident(s)	High Blood Pressure Self Family
Left Knee		High Cholesterol Self Family
Right Knee	Motorcycle(s)	Kidney Disease Self Family
Lasik		Liver Disease Self Family
Left Shoulder		Migraine Headaches Self Family
Right Shoulder	Boating Accident(s)	Multiple Sclerosis Self Family
Thyroidectomy		Osteoarthritis Self Family
Tonsils	***RESULT OF ACCIDENT(S)*** ❒ ***NONE***	Pacemaker Self Family
Tonsils & Adenoids	Fracture(s)	Parkinson's Disease Self Family
Transplant	Permanent injury or disability	Pneumonia Self Family
Wisdom Teeth	Hospitalization(s)	Polio Self Family
WORK STATUS	No significant injury or loss	Prostate Problems Self Family
Full Time Part Time Home Maker Retired Student Unemployed	I am no longer receiving treatment for the above injuries	Psychiatric Care Self Family
Hours per week: 0 – 20 20 – 40		Rheumatoid Arthritis Self Family
40 – 50 50 – 60 60 – 70 70+		Seizure Self Family
At work I mostly: Sit Stand		Stroke Self Family
Labor Intensity: Light Moderate Heavy Sedentary		Suicide Attempts Self Family
I consider my work to be: Difficult Enjoyable Relaxed Stressful	***CHIROPRACTIC HISTORY***	Thyroid Problems Self Family
	Have you been adjusted by a *chiropractor* before? ❒ YES ❒ No If so, when? _____	Tumor Self Family
		Ulcers Self Family
		Vaginal Infection Self Family
		Venereal Disease Self Family

ALL WAYS CHIROPRACTIC
Informed Consent

The Nature of Chiropractic Treatment:
The Doctor will use his/her hands or a mechanical device to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked". You may also feel movement of the joint. Various ancillary procedures such as ice and heat therapy, laser therapy, therapeutic exercise and decompression therapy may also be used.

Possible Risks:
As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include but are not limited to fractures, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to the arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of Risks Occurring:
The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications that are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over the counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys and other side effects in a significant number of cases.
- *Medical Care*, typically anti-inflammatory drugs, tranquilizers and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significance number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risk of adverse reaction to anesthesia, as well an extended convalescent period in a significant number of cases.

Risks of Remaining Untreated:
Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and, make future rehabilitation more difficult.

Unusual Risks:
I have had the following unusual risks of my case explained to me. I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.

_____ _____
Patients Signature Date

_____ _____
Authorized All Ways Chiropractic Employee Signature Date

ALL WAYS CHIROPRACTIC, PLLC
PATIENT FINANCIAL AGREEMENT

Please ***print your initials on the line*** next to your method of payment. This helps with billing procedures and proper record keeping.

_____ **TIME OF SERVICE (TOS):** Payment is expected as the services are rendered. We accept cash, checks, Master Card, Visa, American Express, Discover, Care Credit, FSA (Flex Savings Account) cards, and HSA (Health Savings Account) cards.

_____ **HEALTH INSURANCE:** Co-payments and co-insurance payments are due at the time of service. Please provide us with a copy of the front and back of your health insurance card. Any quote of benefits we receive from your insurance company does not guarantee coverage or insurance payment. We are not responsible for any changes made to your insurance policy. It is your responsibility to know your insurance benefits. Your insurance claims will be billed by an in-house biller or an employee. You are ultimately responsible for your account, which could include deductibles, co-pays, co-ins, non-covered services and denied services.

_____ **PERSONAL INJURY:** Please provide us with all the necessary information needed for billing. This will include the name and phone numbers of ALL insurance companies involved. The claim number(s), date of accident, ALL insured party's name (including third party name), and/or the name of your attorney, if represented. We require an attorney for all third party claims and for those insured with USAA. Our office does not bill health insurance for personal injury claims. We reserve the right to file a lien at any time. You are ultimately responsible for your account and all charges incurred with our office.

_____ **LABOR & INDUSTRIES:** You are responsible for filling out the Labor & Industries long claim form or the claim form necessary for self-insured businesses, which can be done at our office. If you are switching care from another physician, we have the required transfer card available. If your claim is not accepted or services are not covered, you are ultimately responsible for your account and all charges incurred with our office.

_____ **MEDICARE:** Please provide us with a copy of your Medicare card and supplemental health card, if applicable. You are responsible for your annual deductible that begins each January of the New Year. Medicare does not cover x-rays, examinations or maintenance care. Medicare will only pay for services they determine to be medically necessary. You are ultimately responsible for your account with our office.

-Assignment and Release-

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to All Ways Chiropractic, PLLC, 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 hereby authorize the use of this signature on all insurance submissions.

Treatment provided at All Ways Chiropractic is based upon the condition that is being treated. Therapies provided by Dr. Michael Eekhoff can include 1-2, 3-4 or 5 region chiropractic manipulation, extremity adjustment ie: foot, ankle, shoulder, wrist, elbow, rib etc, self-care home management training as well as mechanical traction. These services are provided on an individual basis depending on what is in the best interest of your body and your healing. Treatment is provided based upon medically necessity and will not be discussed prior to any treatment provided while in the adjusting room. If you have any questions please speak with the Receptionist, Office Manager, Dr. Michael Eekhoff. Other therapies offered at All Ways Chiropractic include laser therapy, decompression therapy, massage therapy, nutrition recommendations and supplements as well as Durable Medical Equipment (DME).

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Doctor Signature Date

_____ _____
Attorney Signature Date

Office Policy

Our goal is to provide exceptional service and ensure that all questions are answered to eliminate confusion when it comes to your care at All Ways Chiropractic. Our office policy allows us to convey how our office operates, while allowing us to meet our goals of exceptional service. Please read our Office Policy carefully. If you have any questions, please do not hesitate to ask any member of our staff.

1) We bill your health insurance as a courtesy to you, along with all required documentation. However, we are NOT participating with ALL insurance companies. It is your responsibility to note any coverage differences when we are an out of network provider.
2) We make every attempt to accurately verify your insurance coverage and to accurately estimate any out-of-pocket expenses you may have. However, it is ultimately your responsibility to understand your plan benefits. It is your responsibility to know if a referral or authorization is required, what services are covered or not covered, and any out-of-pocket expenses under your policy benefits.
3) You are ultimately responsible for your care and agree to accept full responsibility for all services rendered whether they are a covered service or a non-covered service by your insurance policy.
4) According to your personal health insurance benefits you may be responsible for a deductible, co-pay and/or co-insurance. Those fees are due to All Ways Chiropractic and will be collected based upon your health insurance policy benefits and claims processing determination.
5) All Ways Chiropractic does not bill Durable Medical Equipment (DME) supplies to health insurance companies. The cost of all supplies are to be paid directly to All Ways Chiropractic on the date of the purchase. You have the option of submitting a claim to your health insurance company if you choose.
6) If you do not have health insurance, maxed out your Chiropractic benefits, or are on maintenance care plan we will extend our Time of Service (TOS) rates to you. The TOS fee is to be paid at the TOS, no exceptions. Our office saves on clerical costs which allows All Ways Chiropractic to extend those savings to you. To be eligible for our TOS rates you must pay for your care at the TOS. We do not send bills. If we are forced to send a bill due to non-payment at the Time of Service for a forgotten wallet, etc. the reduced rate will be reversed to our actual fee for service. To avoid any issues, payment for a TOS adjustment is due prior to receiving your adjustment.
7) Patient statements are sent monthly and should arrive to you mid-month.
8) We reserve the right to send any unpaid balances to a collection agency.
9) A fee of $25.00 will be assessed on any returned checks.
10) We require 24-hour notice when cancelling a massage. If 24-hour notice is not provided to All Ways Chiropractic then a NO SHOW fee will be added to your account in the amount of $45.00 for the first NO SHOW, and $65.00 for each NO SHOW thereafter. Any NO SHOW fees incurred will be *your* responsibility, regardless if you are being treated on an injury claim or if we are billing your health insurance. *A NO SHOW fee is NOT covered by any insurance company; therefore, a NO SHOW fee is paid directly to All Ways Chiropractic by the patient.* After too many NO SHOW's (determined by All Ways Chiropractic) which include not providing proper 24-hour cancellation notice or missing the appointment entirely, All Ways Chiropractic reserves the right to not pre-schedule any future massage appointments.
11) If you receive an updated insurance card due to switching plans, a new calendar or fiscal year commences, or you completely change health insurance companies, All Ways Chiropractic requires a copy of the new card if you would like us to continue billing for payment for services rendered. Otherwise, you are welcome to utilize our TOS rates.

12) There are times when insurance policies change throughout the year, which might change your out-of-pocket expense. If this happens you should be notified by your insurance company. It is not the responsibility of All Ways Chiropractic to stay up to date on your insurance policy and available benefits.
13) Know your benefits. Your insurance policy informs you of your available health insurance benefits. MOST insurance plans limit the number of Chiropractic, massage and physical therapy benefits that are available for your use. All Ways Chiropractic does our due diligence to keep track of how many visits you have used at our office. However, it is ultimately your responsibility to know how many times you come in for care. This includes visiting other Chiropractic offices, as *ALL* Chiropractic visits count towards your Chiropractic benefit, regardless of the Doctor of Chiropractic you have seen. If you are treated more than what your benefits allow then then each visit thereafter will deny, and the cost for your visit will be our actual fee for service. Deductible, co-pay and co-insurance amounts do not apply to maxed benefits.
14) If you have an open injury claim due to an auto accident, pedestrian related injury, work injury or a slip and fall, please notify the front desk. Please supply All Ways Chiropractic with the Date of Injury (DOI), type of claim ie: MVA or work injury claim, name of the insurance company, claim number, phone number, name of the adjuster and attorney information.

Let's all work together for the benefit of you and your health!

Patient Name:_____ Date:_____

Patient Signature_____ ***Employee Initials***_____

All Ways Chiropractic
3773 Martin Way E. Suite B-106
Olympia, WA 98506
Ph: (360) 352-8896 ***Dr. Michael Eekhoff, B.A., D.C. CICE*** Fax: (360) 705-0633

Notice of Privacy Practices: Signature Page

This notice describes how All Ways Chiropractic PLLC may use and disclose your medical information, and how you may access this information. Please review this notice carefully. If you have any questions about this notice, please contact our privacy officer at 360-352-8896 or email at officemanager@allwayschiro.com.

We are required by law to maintain the privacy of your protected Health Information, to notify you of legal duties and privacy practices with respect to your health information and to notify affected individuals following a breach of unsecured health information. This notice summarizes our duties and your rights concerning your information.

This Notice of Privacy Practices describes All Ways Chiropractic PLLC practices and that of any of our affiliates. All employees, staff and other personnel will follow the terms of this notice. In addition, these entities, sites, and locations may share medical information with each other for treatment, payment or health care operation purposes as described in this Notice.

Changes to this Notice:
We reserve the right to change the terms of our Notice at any time. Any revisions of the Notice will be effective for all Protected Health Information that we maintain at that time. To receive a copy of the revised Notice, you may contact our Privacy Officer and request that a revised copy be sent to you in the mail. Additionally, you may also obtain a copy at the front desk at your next appointment.

All Ways Chiropractic PLLC is committed to protecting your medical information:
We understand and appreciate the personal nature of any information related to you and your health. All Ways Chiropractic PLLC is committed to protecting your medical information, and are required by law to:

- Ensure the privacy of your identifiable medical information
- Provide you with this notice of our legal duties and privacy practices with respect to your medical information
- Follow the terms of the most current Notice.
- I acknowledge I have received a hard copy of All Ways Chiropractic notice of patient privacy policy. Please initial on the line. _____

I have read and understand the Notice of Privacy Practices from All Ways Chiropractic PLLC.

_____ _____
Patient Printed Name Date

_____ _____
Patient Signature AWC Employee Initial

NOTICE OF PRIVACY POLICY:
This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information to carry out treatment, payment, or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information. "Protected Health Information" refers to information about you, including demographic information that may identify you, and relates to your past, present or future physical, mental or health condition related to healthcare services.

Uses and Disclosures of Protected Health Care Information Based Upon Your Written Consent.
You will be asked by All Ways Chiropractic PLLC to sign a consent form. Once you have consented to use and disclosure of your protected Health Information for treatment, payment, and health care operations by signing the consent form, All Ways Chiropractic PLLC will use or disclose your Protected Health Information as described in this section. Each category of uses and disclosures will be explained but not every use or disclosure in each category will be listed. However, every permissible use or disclosure will fall under one of the following categories.
Treatment: We will use and disclose your Protected Health Information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your Protected Health Information.
Payment: Your Protected Health Information will be used and disclosed, as needed, to obtain payment for your health care services. Other uses and disclosures may include certain activities that your health insurance plan may undertake before it approves, or pays, for the health care services we recommend for you. For example, insurance companies that require us to relay to them the services or treatment you are going to receive, or have received in this clinic, so they may determine coverage and payment.
Health Care Operations: We may use or disclose, as needed, your Protected Health Information for operations and business activities. These activities include, but are not limited to, quality assessment activities, employee review activities, employee training, licensing, marketing and fundraising activities, conducting or arranging for other business activities, and compliance with state law. For example, we may disclose Protected Health Information to employees and massage therapists that interact with those patients within our clinic. In addition, we may use a sign in sheet at the front desk where you will be asked to sign your name. We may also call you by name in the waiting room when your treating provider is ready to see you. We may use or disclose your Protected Health Information, as necessary, to contact you to remind you of your appointment. Your Protected Health Information might be visible to third party "business associates" that perform various activities such as IT. Whenever an arrangement between our office and a business associate involves the use or disclosure of your Protected Health Information, we will obtain a written contract that contains terms that will protect the privacy of your Protected Health Information. We may use or disclose your Protected Health Information, as necessary to other providers, to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you. We may use and disclose your Protected Health Information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you.
Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization:
Other uses and disclosures not described in this Notice will be made only with your written authorization. You may revoke your written consent by submitting a written notice to the Privacy Officer. The revocation will not be effective to the extent that All Ways Chiropractic PLLC has already acted in the reliance of the authorization. Once your revoked authorization is received, and approved, then any/all activities pertaining to the specific uses and disclosures will cease.
Other permitted and Required Uses and Disclosures That May Be Made with Your Consent, Authorization or Opportunity to Object: You will be granted the opportunity to agree or object to the use or disclosure of all or part of your Protected Health Information. If you are not present, not able to agree, or object to the use or disclosure of the Protected Health Information, then in our best professional judgment All Ways Chiropractic PLLC may determine whether the disclosure is in your best interest. In this case, only the minimum necessary Protected Health Information relevant to your health care will be disclosed.
Others Involved in Your Healthcare: Unless you instruct us otherwise, during an emergency we may disclose to a member of your family, relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree, or object, to such a disclosure we will determine what is in your best interest based on our professional judgment. We may use or disclose Protected Health Information to notify, or assist in notifying, a family member, personal representative, or any other person that is responsible for your care or general condition. Finally, we may use or disclose your

Protected Health Information to an authorized public or private entity to assist in disaster relief efforts, to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your Protected Health Information in an emergency treatment situation. If this happens, All Ways Chiropractic PLLC staff shall attempt to obtain your consent as soon as reasonably practicable after the delivery of treatment. If the doctor or any staff member at All Ways Chiropractic PLLC is required by law to treat you,

and has attempted to obtain your consent yet is unable to obtain your consent, he or she may still use or disclose the minimum necessary Protected Health Information to treat you.

Communications Barriers: We may use and disclose your Protected Health Information if we attempt to obtain consent from you but are unable to do so due to substantial communication barriers. We will determine, using professional judgment, if you intended to consent to use or disclose under these circumstances

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity:

We may use or disclose your Protected Health Information in the following situations without your consent or authorization. These situations include, but are not limited to the following:

When Required By Law: We may use or disclose your Protected Health Information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the minimum necessary. You will be notified, as required by law, of any such uses or disclosures. We may use or disclose your information to state agencies for registry purposes as appropriate and required under State of Washington law.

Public Health: We may disclose the minimum necessary amount of your Protected Health Information for public activities to a public health authority that is permitted by law to collect or receive the information. These uses and disclosures may include, but are not limited to the following:

- To prevent disease, injury, or disability.
- To report child abuse or neglect by making a telephone report to the appropriate authorities, and to follow this report with a written confirmation.
- To report reaction to medication of problems with products required by the Food and Drug Administration.
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- To notify the appropriate government authority if we believe a client has been the victim of domestic violence. We will only make this disclosure if you agree, and when consistent with the requirements or authorizations of applicable Washington State and Federal Law.

Criminal Activity: Consistent with applicable federal and state laws we may disclose your Protected Health Information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health, safety of a person or the public. We may also disclose Protected Health Information if it is necessary for law enforcement authorities to identify or apprehend an individual. Any such disclosures would be limited to the minimum necessary, and would be made to someone included in the prevention of the threat.

Military Activity: When the appropriate conditions apply, we may use or disclose Protected Health Information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities, for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or to foreign military authority if you are a member of that foreign military services.

Worker's Compensation: We may disclose your Protected Health Information for workers compensation and other similar legally establishes programs, in accordance with state and federal law regarding such disclosures.

National Security: We may disclose your Protected Health Information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Required Uses and Disclosures: By law, we must make minimum necessary disclosures when required to do so by state, federal, or local law.

Your Rights Regarding your Protected Health Information

Following is a statement of your rights with respect to your Protected Health Information and a brief description of how you may exercise these rights.

Right to Inspect and Copy: This means you may inspect and obtain a copy of Protected Health Information about you that is contained in a designated record set for as long as we maintain the Protected Health Information. A "designated record set" contains medical and billing records and any other records that your physician and the

practice uses for making decisions about you. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record. To inspect and/or copy your medical information maintained by All Ways Chiropractic PLLC you must submit your request in writing to the front desk. You may be charged a fee for the administrative costs of retrieving, copying, mailing, and any other activities associated with your request.

Right to Request an Amendment: If you feel any of your medical information maintained by All Ways Chiropractic PLLC is incorrect or inaccurate you may request an amendment of that information for as long as we maintain this information. In certain cases, we may deny your request for an amendment. To request an amendment, your request must be made in writing and must include the reason for the request. All requests for amendment are to be submitted to the front desk. All Ways Chiropractic PLLC reserves the right to deny your request for amendment for any of the following reasons:

- The information is complete and accurate
- We did not create the information
- The person or entity that created the information is no longer available to make the amendment
- The information is not part of the medical information kept by our facility
- The request pertains to information that you are not permitted to inspect and copy.

You have the right to file a statement of disagreement with us. In turn, we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

Right to an Accounting of Disclosures: This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices for a time frame of up to seven (7) years from the date of the request. It excludes routine disclosures, such as any we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. To request an accounting of disclosures, you must submit a written request to the front desk. Your request must state a time period, which may not exceed Seven years. You will not be charged for the first request for accounting within a twelve-month period, however, you may be charged a fee for the administrative costs of retrieving, copying, mailing, and any other activities associated with any additional requests for accounting. You will be notified of the costs involved and will have the option to withdraw your request at that time, before any costs are incurred.

Right to Request Restriction: You have a right to request that All Ways Chiropractic PLLC restrict the use or disclosure of any part of your Protected Health Information for the purposes of treatment, payment, or health care operations. You may also request that your Protected Health Information be disclosed to family members or friends for notification purposes. You may request additional restrictions on the use or disclosure of information for treatment, payment, or health care operations. We are *not* required to agree to the requested restrictions except in the limited situation in which you or someone on your behalf pays in full for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer.

Right to Request Confidential Communications: You have the right to request to receive confidential communications from All Ways Chiropractic PLLC by alternative means or at an alternative location. For example, you may wish to be contacted only at work or by mail. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. This request must be made in writing to the front desk and must specify how and where you wish to be contacted.

Right to obtain a copy of this Notice: You have the right to obtain a copy of this Notice of Privacy Practices upon request. To receive a copy of this Notice, or any future revisions of the Notice, you may contact our Privacy Officer and request that a revised copy be sent to you in the mail. Additionally, you may also obtain a copy at the front desk at the time of your next appointment.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with All Ways Chiropractic PLLC or with the Secretary of Health and Human Services. You may also contact our Privacy Officer for further information about the complaint process. We will not retaliate against you for filing a complaint.