All Ways Chiropractic

655 Golf Club Place SE Suite C
Lacey, WA 98503
Ph: (360) 352-8896
Fax: (360) 705-0633

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: _____

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Massage Intake Questionnaire

Patient Name: _____ Date: _____

What is your occupation? _____
Are you allergic to anything? _____
Are you taking any medications? _____
Are you pregnant? _____ Due Date: _____
Do you smoke? (please circle) Yes No If yes, how often per week? _____
Consume alcohol? (please circle) Yes No If yes, how often per week? _____
Exercise? (please circle) Yes No If yes, how often per week? _____

Present Complaints: (please circle)

Headaches	Mental Dullness	Loss of Memory	Dizziness
Neck Pain	Upper Back Stiffness	Mid Back Stiffness	Lower Back Stiffness
Neck Restrictions	Nervousness	Hands/Feet Cold	Depression
Rib Pain	Shortness of Breath	Eye Strain/Pain	Confusion
Blurred Vision	Constipation	Unbalanced	Chest Pain
Ears Ringing	Irritability	Tension	Fainting
Upper Back Pain	Mid Back Pain	Lower Back Pain	Pins & Needles in Neck/Arms/Hands

How would you rate the level of discomfort on a scale of 1 to 10?

1 2 3 4 5 6 7 8 9 10

What is the frequency of the discomfort?

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How bad is the discomfort at its worst?

1 2 3 4 5 6 7 8 9 10

How would you rate the discomfort at its best?

1 2 3 4 5 6 7 8 9 10

When did the discomfort begin? _____

Please list all injuries & dates: _____

_____

Please list all operations/surgeries & date: _____

_____

Describe the onset of the discomfort: Gradual Sudden
Comments: _____

What movement(s) aggravates the discomfort?

Bending	Carrying	Climbing	Coughing	Crawling
Dressing	Driving	Eating	Exercising	Jumping
Kneeling	Lifting	Lying Down	Pulling	Pushing
Reaching	Sitting	Sleeping	Sliding	Sneezing
Standing	Turning	Twisting	Typing	Walking

What percentage would you say that the discomfort worsens after it is aggravated?

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How long does the discomfort remain that way? _____

What relieves the discomfort?

Ice	Heat	Exercising	Lying Down	Stretching
Resting	Sleeping	Sitting Down	Walking	Massage
Chiropractic	Medication	Other:_____		

What percentage would you say that the discomfort improves after trying the above activities?

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

What is the quality of the discomfort?

Dull	Sharp	Aching	Burning	Shooting	Sensitivity
Pressure	Tingling	Numbness	Throbbing	Tightness	Stiffness
Deep	Continuous	Frequent	Intense	Intermittent	Mild
Moderate	Severe	Other:_____			

When is discomfort at its worst?

Morning Afternoon Evening Just before bed Other:_____

_____ _____

Patient Signature Date

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Massage Informed Consent

I, (please print your full name) _____, have chosen to consult with and hereby give consent for massage therapy to be provided by an All Ways Chiropractic Licensed Massage Therapist.

I have provided a detailed medical history. I do not expect the therapist to have foreseen any previous or pre-existing condition that I have not mentioned.

I understand that massage may provide benefits for certain conditions but results are not guaranteed. These benefits may include relief of muscular tension, relaxation, reduction in the symptoms of stress-related conditions and provision of general well-being.

I also understand that massage therapy may produce side effects such as increased muscle soreness, mild bruising, light-headedness, increased inflammation, fatigue or tiredness, possible headache and/or nausea. Typically, it is rare to experience all of these symptoms at once.

I am aware that the therapist does not diagnose illnesses, prescribe medications nor physically manipulate the spine or its immediate articulations.

The therapist understands that I have the right to question procedures used and to receive an explanation of any procedure that the therapist performs.

It is important to communicate with the therapist. I will inform the therapist about any discomfort I am experiencing during the therapy session and understand that the therapy will be adjusted accordingly.

_____ _____

Patient or Parent/Guardian Signature Date

_____ _____

Authorized All Ways Chiropractic Employee Signature Date

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Massage Therapy No Show Policy

We strive to render excellent care to you and the rest of our patients. In an attempt to be consistent with this, we have an Appointment Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

Our policy:

NO-SHOW: includes not providing proper 24-hour cancellation notice, being 15 minutes or more late or missing the appointment entirely.

We require a 24-hour notice in the event that you need to reschedule or cancel your appointment. As a courtesy All Ways Chiropractic will waive the first No-Show fee.

If 24-hour notice is not provided to All Ways Chiropractic this will be counted as a NO-SHOW. Any NO-SHOW fees incurred will be ***your*** responsibility, regardless of 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… immediately.***

The second no show, and any further no shows, are a **$65 charge.**

As a courtesy if you are unable to show for your massage and we do fill your appointment, we will not charge you for the No-Show.

Should you arrive after the 15-minute grace period and your massage has not been filled, you as the patient have the choice to either forgo your massage and consider it as a No-Show, or have a shortened massage that will be charged in full. After your second NO-SHOW, All Ways Chiropractic reserves the right to not pre-schedule any future massage appointments.

By signing below, you are acknowledging that you understand this policy, and that you are financially responsible should these charges occur.

_____

Patient Name (please print)

_____ _____

Patient or Parent/Guardian signature Date

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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) As a courtesy, All Ways Chiropractic will bill your health insurance and submit required documentation on your behalf. However, we are not participating providers with all insurance plans. Verification of benefits is an estimate and not a guarantee of payment, as all coverage determinations are made by your insurance carrier once claims are processed.
2) It is your responsibility to understand your individual insurance benefits, including covered and non-covered services, referral or authorization requirements, deductibles, co-payments, co-insurance, and visit limitations. You are financially responsible for all services rendered regardless of your insurance company's payment determination.
3) If your insurance policy changes at any time, including a new plan year, change of carrier, or updated benefits, you must provide a copy of your current insurance card if you would like us to continue billing your insurance. If updated information is not provided and services have been billed to the insurance on file, you are responsible for the full-service charge. Insurance policies may change throughout the year, and it is your responsibility to notify our office of any benefit changes that may affect your coverage.
4) Payment for deductibles, co-payments, co-insurance, and non-covered services is due at time of service. Patient statements are sent monthly and typically arrive mid-month. Any unpaid balance may be referred to a collection agency. A fee of $25 will be assessed for any returned checks. We reserve the right to discontinue care in situations involving non-compliance with this Office Policy.
5) Time of Service (TOS) rates are available for patients without insurance coverage, patients who have exhausted their chiropractic benefits, or patients receiving maintenance care. TOS rates require payment at the time services are rendered, and we do not send bills for these accounts. If payment is not made at the time of service, discounted TOS rates will revert to our standard fee schedule.
6) TOS packages are non-transferable and may not be shared with or applied to another individual, including family members. If care is discontinued before a package is completed, visits used will be recalculated at the standard fee. Any credit balance will be refunded within 30 days, and any remaining balance owed will be due immediately.
7) Many insurance plans limit the number of chiropractic and massage therapy visits allowed per calendar year. While our office tracks visits provided at All Ways Chiropractic, it is ultimately your responsibility to monitor your total visits, including services received at other facilities. All chiropractic visits count toward your annual benefit maximum regardless of the provider seen. Once benefits are exhausted, services will be billed at our standard fee, and deductibles, co-payments, and co-insurance amounts no longer apply.
8) All Ways Chiropractic does not bill insurance companies for Durable Medical Equipment supplies. Payment for these items is due at the time of purchase. If you choose, you may independently submit a

claim to your insurance company for potential reimbursement.

9) We require a 24-hour notice to cancel a massage appointment. The first missed appointment will be waived as a one-time courtesy and documented in your account. Any subsequent missed appointments or failure to provide proper notice will result in a $65 fee. No-show fees are not billable to insurance and are paid directly to All Ways Chiropractic. No-show fees are the sole responsibility of the patient. All Ways Chiropractic reserves the right to NOT pre-schedule future massage services after repeated missed appointments.
10) Lumbar Decompression Therapy is not covered by health insurance. A consecutive four-day trial is available for patients who are a candidate for Decompression Therapy. Following the trial period, a customized treatment plan and associated discount service agreement will be presented. If you choose to discontinue decompression care at any time, services rendered will be recalculated at the full rate up to the last date of treatment. Any credit balance will be refunded within 30 days, and any outstanding balance will be due immediately upon cancellation. Pay-as-you-go options are also available without a signed agreement.
11) If you are receiving care related to an auto accident, work injury, pedestrian injury, or slip and fall claim, you must provide the Date of Injury, type of claim, insurance company name, claim number, adjuster contact information, and an attorney information if applicable. You remain financially responsible for all services until payment is received.
12) ATTORNEY'S OBLIGATION: If you are represented by an attorney, the attorney is instructed to withhold sufficient funds from any settlement proceeds to satisfy the outstanding balance owed to All Ways Chiropractic, PLLC and to remit payment directly upon resolution of the case. The attorney further agrees to notify our office if legal representation is terminated for any reason.

Acknowledgement

I have read and understand the Office Policy of All Ways Chiropractic. I agree to comply with the policies outlined above and accept financial responsibility for services rendered.

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

Patient Name:_____ Date:_____

Patient Signature_____ *Employee Initials*_____

ALL WAYS CHIROPRACTIC, PLLC

ASSIGNMENT OF BENEFITS & PATIENT FINANCIAL AGREEMENT

RELEASE OF INFORMATION: I authorize **All Ways Chiropractic** to disclose and release to my insurance carrier(s), including Medicare, Medicaid, Medigap/Supplemental benefits providers, and private insurers, as applicable, any medical and treatment information needed for payment purposes for services rendered. I authorize use of this form for the release of information needed to process claims to all my insurance carrier(s) and its authorized agents. I authorize my provider/practice to act as my agent in helping obtain payment from my insurance companies.

ASSIGNMENT OF BENEFITS: I assign all payments, rights and claims for reimbursement of claims, costs, and expenses allowable under my insurance plan(s) directly to my provider or practice for services rendered. I understand I will receive a statement for any balance owed by me and agree to make full payment upon receipt of the statement after insurance has met its obligation. I understand it is my responsibility to provide All Ways Chiropractic with all my insurance information. *If I fail to provide all my insurance information to All Ways Chiropractic for billing of services rendered in a timely manner according to my insurance companies billing guidelines, I will be responsible for all charges for services rendered.*

Please print your initials on the line next to your billing and payment case type.

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

---------- **HEALTH INSURANCE**: Co-payments are due at the time of service. Co-insurance and deductibles are due upon insurance processing. I have provided All Ways Chiropractic with a copy of the front and back of ALL my health insurance cards. I understand that any quote of benefits from my insurance company does not guarantee coverage or insurance payment. All Ways Chiropractic is not responsible for any changes made to my insurance policy. It is my responsibility to know my insurance benefits. My insurance claims will be billed by an employee or billing company hired by All Ways Chiropractic. I understand and accept that I am ultimately responsible for my account, which could include deductibles, co-pays, co-ins, non-covered services and denied services.

---------- **PERSONAL INJURY**: I have provided All Ways Chiropractic with the name and phone numbers of ALL insurance companies involved in the settlement of my injury claim. This includes claim number(s), date of injury, ALL insured party's name (including third party name), and/or the name of your attorney, if represented. ***All Ways Chiropractic requires an attorney for all third-party claims.*** I accept that All Ways Chiropractic does not bill health insurance for personal injury claims, unless no other insurance is available. We reserve the right to file a lien at any time. I understand I am ultimately responsible for my account and all charges incurred within. **No Recovery:** If no settlement or judgement is received, or if the recovery is insufficient to cover all fees and costs, the patient is still personally responsible for paying the full balance owed to **All Ways Chiropractic, PLLC.**

---------- **LABOR & INDUSTRIES**: I understand I am responsible for reporting my injury to the Department of Labor Industries or to the self-insured company retained by my employer. If I am switching care from another physician, I understand that All Ways Chiropractic has the required transfer card available to me. If my claim is not accepted or services are not covered, I understand I am ultimately responsible for my account with All Ways Chiropractic and all charges incurred within.

---------- **MEDICARE**: I have provided a copy of my Medicare card and supplemental health card, if applicable to All Ways Chiropractic. As a Medicare beneficiary, I understand my signature requests payment to be made and authorize the release of medical information necessary to pay claims. If 'other health insurance' is indicated in item 9 of the HCFA-1500 Form, or elsewhere on approved claim forms, or electronically submitted claims, my signature authorizes the release of information to insurance companies or its authorized agents. In Medicare-assigned cases, the physician or supplier agrees to accept the charge of determination of the Medicare carrier as the full charge, and I agree I am responsible for deductible, coinsurance, and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier.

---------- **VETERANS AFFAIRS (VA):** An authorization if required for claim payment. I understand it is my responsibility to obtain this authorization either through my Community Care Provider or from the VA directly. I understand that without a valid authorization on file with the VA , my claims will NOT be paid.

Signature of Patient or Authorized Representative	Printed Name of Authorized Representative
Printed Name of Patient	Date

Revised 02/17/2026 JMR

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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