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 understand 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 curtesy 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 is a **$50 charge.**
Further no shows are a **$65 charge.**

As a courtesy if you are unable to show for your massage and we are able to 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) 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 $50.00 for the second 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.
15)

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

Patient Name:_____ Date:_____

Patient Signature_____ ***Employee Initials***_____