All Ways Chiropractic
Michael Eekhoff, B.A., D.C.
655 Golf Club Place SE Suite C Lacey, WA 98503
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: _____

Name:_____

Date of Injury: _____

Please Describe How Your Work Injury Occurred

_____

_____

Symptoms From Your Work Injury

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

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

Prior Similar Symptoms

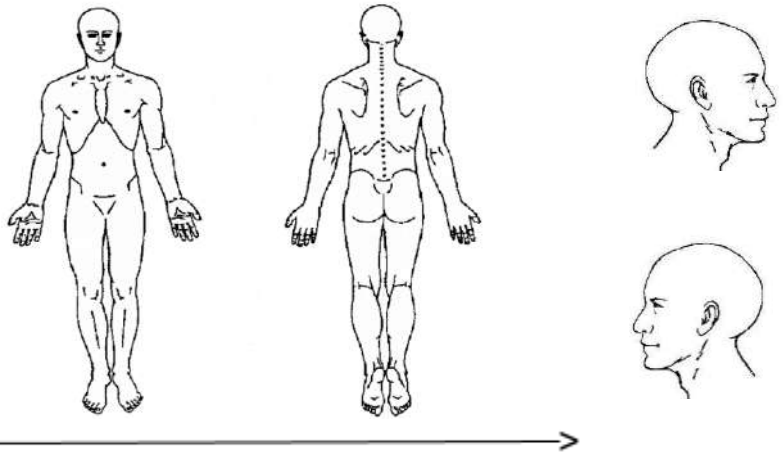
4. Did you have any physical complaints **just before your work injury**? ❒ Yes ❒ No
   If yes, describe:_____
5. **Prior** to work injury, have you **ever** had symptoms similar to what you are experiencing now?
   ❒ Yes ❒ No
   If yes, please explain (briefly include past falls, injuries, collisions, operations, etc.):_____
   _____
6. Are these symptoms worse since your work injury? ❒ Yes ❒ No

Activities of Daily Living

7. Do you notice any of your home activities that are different now than from before your work injury? ❒ Yes ❒ No
   (If yes, please list them): _____
8. The activities that are now painful to do are: _____

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.

Sharp:
XXXXX
Dull/Ache:
^^^^^^
Burning:
= = = =
Numb:
o o o o
Pins/Needles:
+++++++
Other:
/////////



Less Pain More Pain

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

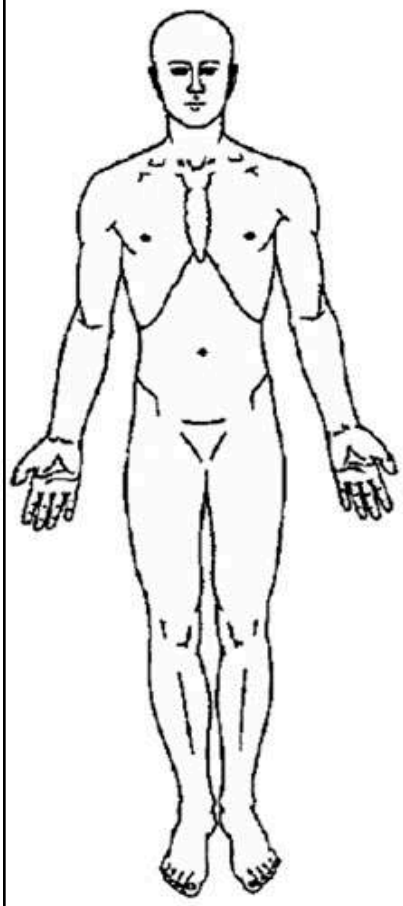
. . . . . .

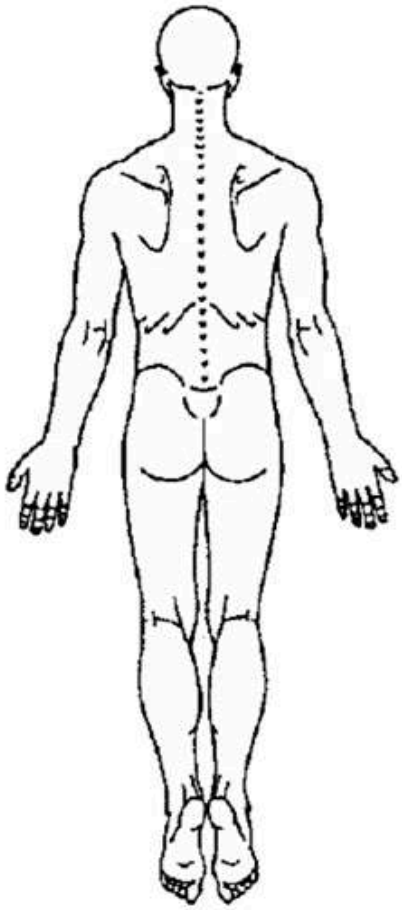
Sharp

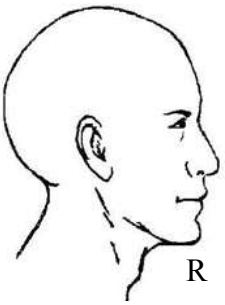
x x x x x x

Other

/ / / / / /







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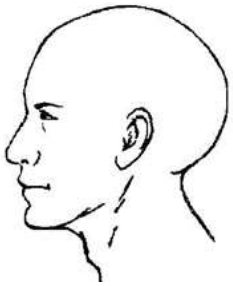

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No Pain ---------- Worst Pain Possible

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 pan occasional _____ Frequent _____ or constant_____?

What makes the pain better? _____

What makes the pain worse? _____

Patient's Name: _____

Patient's Signature: _____

Date Signed: _____

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 everyday 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 weight 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 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 able to engage in a few of my usually 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 hav 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.

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 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 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 if 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 ½ 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 ½ 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 ½ mile without increasing pain.
④ I cannot walk more than ¼ 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 and 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 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.

Back Index Score

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

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***	***Date***
Spinal Fusion	
Discectomy	
Laminectomy	
Abdominal Aortic Aneurysm Repair	
Appendectomy	
Breast Augmentation	
Bunionectomy - Left Side	
Bunionectomy – Right Side	
Cardiac Bypass	
Cardiac Valve Replacement	
Cataract	
C-Section	
Cosmetic	
Carpal Tunnel Syndrome Left	
Carpal Tunnel Syndrome Right	
Ear Tubes	
Gall Bladder Removed	
Ganglion Cyst	
Gastric Bypass	
Hysterectomy Complete	
Hysterectomy Partial	
Left Knee	
Right Knee	
Lasik	
Left Shoulder	
Right Shoulder	
Thyroidectomy	
Tonsils	
Tonsils & Adenoids	
Transplant	
Wisdom Teeth	

MEDICATIONS ❒ ***NONE*** *OTC = Over the Counter* *RX = Prescription*		
Muscle Relaxer	❒ OTC	❒ RX
NSAID/Ibuprofen	❒ OTC	❒ RX
Tylenol	❒ OTC	❒ RX
Pain Reliever/Pain Killer	❒ OTC	❒ RX
Antacid	❒ OTC	❒ RX
Anti-Depressant	❒ OTC	❒ RX
Anti-Viral	❒ OTC	❒ RX
Aspirin	❒ OTC	❒ RX
Birth Control	❒ OTC	❒ RX
Blood Pressure	❒ OTC	❒ RX
Chemotherapy	❒ OTC	❒ RX
Codeine	❒ OTC	❒ RX
Hallucinogenic	❒ OTC	❒ RX
Marijuana	❒ OTC	❒ RX
Mood Elevator	❒ OTC	❒ RX
Sleeping Pill	❒ OTC	❒ RX
Stimulant	❒ OTC	❒ RX
Tranquilizer	❒ OTC	❒ RX
Other	❒	
Allergies to any medications		

ACCIDENT(S) HISTORY ❒ ***NONE***
If yes, when?
Single/Multiple Auto Accidents
Single/Multiple Motorcycle Accidents
Single/Multiple Boating Accidents
Other:

PERSONAL & FAMILY HEALTH HISTORY ❒ ***NONE*** ❒ ***OTHER***		
Cancer	Self	Family
AIDS/HIV	Self	Family
Alcoholism	Self	Family
Alzheimer's	Self	Family
Anemia	Self	Family
Arthritis	Self	Family
Asthma	Self	Family
Bleeding Disorders	Self	Family
Bronchitis	Self	Family
Chemical Dependency	Self	Family
Depression	Self	Family
Diabetes	Self	Family
Eating Disorder	Self	Family
Emphysema	Self	Family
Epilepsy	Self	Family
Fractures	Self	Family
Heart Disease	Self	Family
Hepatitis	Self	Family
Hernia	Self	Family
Herniated Disc	Self	Family
High Blood Pressure	Self	Family
High Cholesterol	Self	Family
Kidney Disease	Self	Family
Liver Disease	Self	Family
Migraine Headaches	Self	Family
Multiple Sclerosis	Self	Family
Osteoarthritis	Self	Family
Pacemaker	Self	Family
Parkinson's Disease	Self	Family
Pneumonia	Self	Family
Polio	Self	Family
Prostate Problems	Self	Family
Psychiatric Care	Self	Family
Rheumatoid Arthritis	Self	Family
Seizure	Self	Family
Stroke	Self	Family
Suicide Attempts	Self	Family
Thyroid Problems	Self	Family
Tumor	Self	Family
Vaginal Infection	Self	Family
Venereal Disease	Self	Family

WORK STATUS
Full Time Part Time Home Maker Retired Student Unemployed
Hours per week: 0 – 20 20 – 40 40 – 50 50 – 60 60 – 70 70+
Occupation:
At work I mostly: Sit Stand
Labor Intensity: light Moderate Heavy Sedentary
I consider my work to be: Difficult Enjoyable Relaxed Stressful

RESULT OF ACCIDENT(S) ❒ ***NONE***
Fracture(s)
Permanent injury or disability
Hospitalization(s)
No significant injury or loss

CHIROPRACTIC HISTORY
Have you seen a *chiropractor* before? ❒ YES ❒ No If so, when? ____

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. Unusual risks associated with spinal decompression include but are not limited to; Acid Reflux, muscle strain, skin irritation, and claustrophobia. However, these risks are considered "rare".

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

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*_____

Revised 02/26/2026 JMR

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

All Ways Chiropractic

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