Life in Balance Family Chiropractic 425-333-4040
31722 W. Eugene St. Suite 6, Carnation, WA 98014-0203

Full Name (First, Middle, Last): _____

Preferred Name/Nickname: _____ Gender: **Male/Female**

Date of Birth: _____/_____/_____Age:_____

Mailing Address: _____ City: _____ State:_____

Zip Code:_____ Email: _____

Home Phone: _____ Cell Phone: _____

Marital Status (circle one): **Married/Single/Divorced/Widowed/In a relationship**

Spouse/significant other's Full Name:_____

Phone number: _____

Emergency Contact: ☐ Check here if information is same as Spouse.

Name: _____

Relationship to Patient: _____ Phone:_____

Employment Status: **Homemaker/Full-Time/Part-Time/ Student/Retired**

Occupation(s): _____ Number of years at this job: _____

Current Medications: _____

_____

_____

Current Vitamins, Minerals, Herbs, Supplements, etc: _____

_____

_____

Have you ever been to a chiropractor before? **Yes/No**

How did you hear about us? Please check all that apply:

☐ Walking-By ☐ Friend: _____

☐ Website ☐ Flyer in Mail ☐ Facebook

☐ Pinterest ☐ Twitter ☐ Instagram

☐ Other: _____

What symptom(s) or condition(s) are you looking for assistance with (ex. neck pain, carpal tunnel, etc)?

_____

_____

_____

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Financial Policy

Insurance Coverage:
Welcome to Life in Balance Family Chiropractic. Your insurance policy is an agreement between you and your insurer, not between your insurer and this clinic. Like all types of care, coverage for chiropractic services varies from insurer to insurer and plan to plan. Most insurance policies require the beneficiary to pay co-insurance, co-payment and/or a deductible. Our clinic will call your insurer to verify your benefits, however, we are not responsible for your insurer's final payment and benefit determinations. **If your account is unpaid by $100+ you will not be able to schedule another appointment until the balance is paid off.**

Payments: In order to help you determine your responsibility toward payment for services, please read the following, and initial your preference for the method of payment of your account. Please notify this office if the status of your insurance changes. Charges for services are subject to change.

Private Pay: (please initial)

A_____ As **I have no insurance**, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered.

B_____ **I have insurance, but I wish to file my claims personally**, and I agree to assume all responsibility and to keep my account current by paying for each visit at the time services are rendered.

Health Insurance: (please initial)

C_____**I would like this clinic to bill my insurance**. I understand I am responsible for the costs of treatment.

D_____ I am involved in a **Personal Injury (PI)** or **Workers Compensation (WC)** claim case. I would like this clinic to bill the insurance company covering the services. I understand that if the services rendered at this clinic are not covered, I am responsible for the cost of all services performed.

Missed Appointments: It is the policy of Life in Balance Family Chiropractic to assess a $25 missed visit fee to patients who cancel appointments with less than a 24-hour notice. One missed visit will not result in the assessment of a fee, but you will be charged for any additional missed visits. This clinic provides care for many individuals and missed visits result in time lost that could have been used to provide care for others.

_____My initials here indicate that I understand the above missed visit policy.

I understand that the information provided above is complete and true to the best of my knowledge and that all health services rendered to me and charged to me are my personal financial responsibility. I understand and agree to the conditions of this policy.

Signature_____ Date_____

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HIPAA Release of Information Authorization Form

Life in Balance Family Chiropractic keeps a record of the care you receive as well as other information you provide us as needed (address, phone number, etc). You may ask to see a copy of your health information. You may also ask to change the records. We will not disclose your health information to others unless we have your permission to do so or unless the law allows or requires Life in Balance Family Chiropractic to do so. If you wish to see or ask about your health information please contact Life in Balance Family Chiropractic directly. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can get it. By signing this form, you are letting everyone know you received a copy of the Notice of Privacy Practices that explains your rights.

I understand that I have a right to revoke this authorization by providing written notice to Life in Balance Family Chiropractic. However, this authorization may not be revoked if my insurance company, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for coverage of services.

Name (printed): _____

Signature: _____ Date: _____

If applicable, legal representatives sign below:

By signing this form, I represent that I am the legal representative of the patient (member) identified above and will provide written proof (e.g. Power of attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the patient's behalf with respect to this authorization form.

Name of Legal Representative (printed): _____

Signature: _____ Date: _____

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Informed Consent

Healthcare providers are required to advise patients of the nature of the treatment to be provided, the risk and benefits of treatment, and any alternatives to the treatment. There are some risks that may be associated with chiropractic treatment, in particular you should note:

1. While rare, some patients have experienced rib fractures or muscle and ligament strains or strains following treatment;
2. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.
3. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote;

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms. Musculoskeletal care contributes to your overall well-being. The risk of injuries or complications from treatment is substantially lower than that associated with medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed the following with my healthcare provider:

1. The condition that the treatment is to address
2. The nature of the treatment
3. The risks and benefits of that treatment
4. Any alternatives to that treatment

I have had the opportunity to ask questions and receive answers regarding the treatment. I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intent this consent to apply to all my present and future care with Life in Balance Family Chiropractic and its doctors or employees.

Print Name: _____

Signature: _____ Date: _____