Wolf CHIROPRACTIC CLINIC
MASSAGE THERAPY & ACUPUNCTURE

15404 E Springfield Ave Suite 100
Spokane Valley, WA 99037
PH 509.892-9800
FAX 509.892-9998

Massage Patient Information

Date: _____

Patient's Name: _____ Date of Birth: _____

Health History / Treatment Information

Have you ever received a professional massage? ☐ Yes ☐ No Date of last massage: _____

What results do you want from your massage session? _____

_____

List any current medications, including ibuprofen, aspirin, etc: _____

_____

Are you currently under the care of a health provider? ☐ Yes ☐ No Provider: _____

Previous History

Surgeries: _____

Major illnesses or other hospitalizations: _____

Have you ever had: ☐ A car accident ☐ Fractures ☐ Falls ☐ Work Injury

Please describe: _____

Please mark any of the following that you may now have or that you have had in the past:

Bone or Joint Disease	Heart Condition	Emphysema
Tendonitis / Bursitis / Arthritis	Phlebitis / Varicose Veins	Sinus Problems
Sprains / Strains	Blood Clots	Asthma
Low Back / Hip / Leg Pain	High / Low Blood Pressure	Allergies
Neck / Shoulder / Arm Pain	Lymphedema	Lupus
Spasms / Cramps	Thrombosis (Blood Clot)	Difficult Breathing
Jaw Pain / TMJ	Osteoporosis	Migraine / Headaches
Rashes	Cancer / Tumors	Kidney / Bladder Ailment
Diabetes	Chronic Fatigue	Chronic Pain
Sleeping Problems	Addictions: Alcohol/Nicotine/Drugs	Tuberculosis
HIV	Hepatitis B	Hepatitis C

Other_____ Are you Pregnant? Yes No *If yes,* how far along?_____

Please draw the location of your pain or discomfort on the images below.

Use the symbols shown to represent the type(s) of pain:

D=Dull **B=**Burning **N=**Numb **S=**Sharp/Stabbing **T=**Tingling **C=**Cramping

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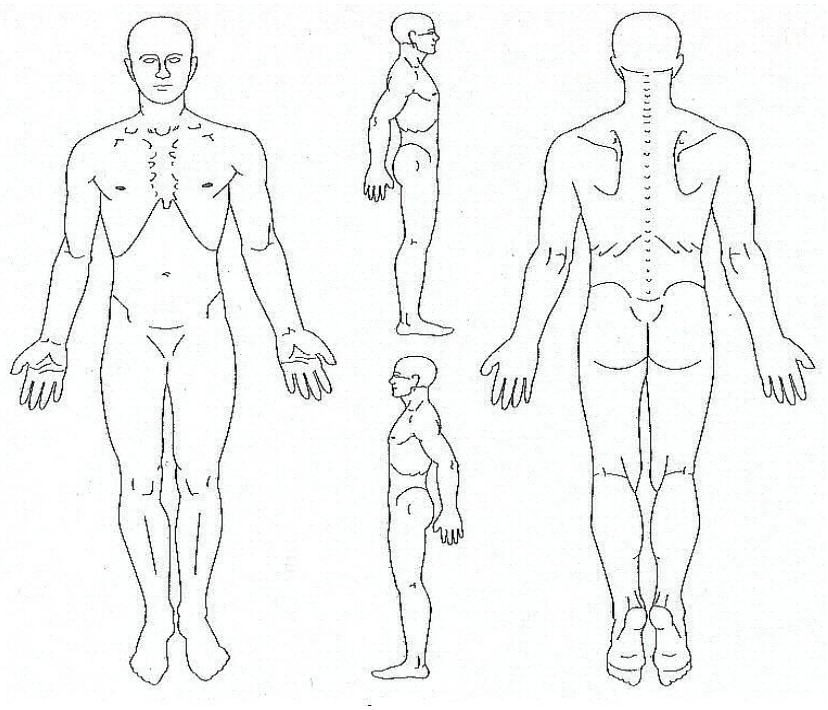

Please rate your current level of pain by circling a number:

0 1 2 3 4 5 6 7 8 9 10

No Pain Low Moderate Intense Emergency

A message therapist must be aware of any existing physical conditions that I have, therefore, I have listed all my known medical conditions and physical limitations and will inform the therapist in writing of any changes in my physical health. I understand that a massage therapist may not diagnose illness, disease, or any medical, physical or emotional disorder, nor perform any spinal or joint manipulation. I am responsible for consulting a qualified physician for any physical ailment(s) that I have. I also understand that the therapist may refuse to treat any area of the body or to terminate the session if any situation should occur that may interfere with the ability to provide quality care. The therapist will disclose those reasons to me. *Patient's initials:* _____

Once your insurance has been verified, we will gladly bill directly to and accept payment from the insurance company. It should be understood that all services are charged to you, the client, who is legally responsible for all payments.
Patient's initials: _____

I understand that if my insurance company requires a referral for massage therapy, it is my responsibility, as the client, to obtain such a referral from a qualified provider, and it will be my responsibility to keep track of the authorized number of visits, and any expiration date that may apply. *Patient's initials:* _____

I understand that if I need to cancel an appointment, I will be required to do so at least 24 hours in advance. *The second missed appointment will be billed to me, the client, and beyond that, my primary care provider will be notified.*
Patient's initials: _____

Patient Information - Please Print Clearly **E-mail Address** _____

Patient Name_____ Date of Birth_____ Age _____

Street & Mailing Address_____ City _____

State_____ Zip _____ Home Phone _____ Cell Phone _____ Sex:
□ Male □ Female □ Married □ Single □ Widow(er) □ Divorced

Social Security # _____ Current Employer _____

Department_____ Work Phone_____ Ok to call at work? Y / N

Spouse, Partner or Guardian_____ Birth Date_____

Address (if different) _____

Employer_____ Work Phone_____

Emergency Contact (person not living with patient) _____

Relationship to Patient_____ Phone _____

Is this visit because you have you been injured in an accident? □ Yes □ No Date of Injury? _____

If yes, was the accident work related? □ Yes □ No Was the injury an auto accident? □ Yes □ No

Have you hired an attorney because of your injury? □ Yes □ No

If yes: Attorney's Name _____ Phone _____

If Work-Related: Employer at time of Injury _____ Phone _____

Claim # _____ Other Insurance? _____

Please Read Carefully:

Our office bills most insurance carriers. All co-pay and deductible amounts are expected to be paid at the time of your appointment unless other arrangements have been made in advance. Should you have a balance for any reason after your insurance has processed our bill, a statement will be sent to you. It will be your financial responsibility to pay this balance due. *Medicare patients* please note that examinations and massage therapy performed in this office are not covered by Medicare and most secondary insurances. _____ Patient Initials

I understand that if my insurance company requires a referral, it is my responsibility to obtain this referral from my medical doctor. I also understand that is my responsibility to fully understand my own insurance benefits and that the benefits quoted to me by this office are based on information provided to Wolf Chiropractic Clinic by my insurance carrier. I accept the full responsibility of keeping track of the number of visits allowed and the number of visits used, regardless of where those services have been performed. The information provided to me by this clinic does not guarantee benefits or coverage for services provided by this office._____ Patient Initials

I have read and understand that if my insurance does not pay in full for the services provided by the health care providers in this clinic, I assume liability for the allowed unpaid portion. I authorize the release of any medical records that might be necessary to facilitate payment of services and authorize the insurance company to make payments direct to the doctors. It is understood that the doctors within this office have access to each other's records without further authorization, and that my records may be released to other physicians directly involved in my care. _____ Patient Initials

I understand that keeping appointments or canceling them with adequate notice prior to my appointment time is my responsibility. Otherwise, I may be charged a regular office visit fee for missed appointments ("no shows")

Date _____ Patient or Guardian Signature_____

INSURANCE COVERAGE DISCLAIMER/CLINIC FINANCIAL POLICY

Insurance coverage is never guaranteed. Many people are under the impression that if they have insurance, it is the insurance company that owes Wolf Chiropractic for their services. This is not the case. ***The insurance contract is between you and your insurance company.*** Effective immediately, Wolf Chiropractic Clinic is encouraging you to personally verify your insurance benefits with your insurance company prior to being seen in our office. As a courtesy, our staff will continue to assist you with your insurance, but any written or verbal information regarding your coverage provided to you by our staff in no way guarantees that your care here will be covered by your insurance company. ***Insurance payment for all services are subject to medical necessity.***

Our Responsibility:

- To bill all claims to your insurance company in a timely manner on your behalf
- To assist you in resolving any problems with your claim payment
- To abide by the rules governing your insurance coverage

Your Responsibility:

- To provide us with your insurance card with current and accurate information to submit your claims correctly
- To assist your provider in obtaining the proper documentation to substantiate the medical necessity of your treatment in this office
- To make certain that there is a prior authorization, prescription and/or referral prior to your treatment if it is required by your insurance and to be aware of the customary charges for the service provided prior to treatment
- To pay your co-pays, co-insurance or deductible payments at the time of service
- To pay for treatment not covered by insurance at the time services are rendered

I understand that if my insurance does not pay in full for the services provided by the health care providers in this clinic, I assume liability for the allowed unpaid amount, within the confines of my policy. I understand that Wolf Chiropractic Clinic will bill most insurance carriers and that all co-pay and deductible amounts are expected to be paid at the time of my appointment unless other arrangements have been made prior to receiving care. Should I have a balance for any reason after my insurance has processed the bills, a statement will be sent to me. It will be my financial responsibility to pay this balance due within 30 days. Unpaid balances owing after 90 days may be sent to a third party collection agency and may have an addition 1.5% interest charge added. Additional collection fees and/or attorney fees will be your responsibility. A $25 processing fee will be added to returned checks. _____ *Patient Initials*

I understand that if my insurance company requires a referral, preauthorization or prescription, it is my responsibility to obtain it **prior** to my appointment. I accept the full responsibility of keeping track of the number of visits allowed, expiration date and the number of visits used, even if those services were performed within another facility or clinic.
_____ *Patient Initials*

In the event of a post-payment audit, recoupment of payments, or failure of my insurance to issue an authorization for services that I believe should be covered, I understand that I am ultimately responsible for payment for services rendered regardless of my insurance coverage. _____ *Patient Initials*

I authorize the release of any medical records that might be necessary to facilitate the payment of services and authorize the insurance company to make payments directly to the clinic and/or provider. It is understood that the providers within this office have access to each other's records without further authorization, and that my records may be released to other physicians directly involved in my care. I have received and agree to the clinic's privacy policy. I agree to inform our clinic immediately and in writing any limitation I wish to be placed on my release of medical records.
_____ *Patient Initials*

I understand that keeping appointments or cancelling them without adequate notice prior to my appointment time is my responsibility. Otherwise, I may be charged a regular office visit fee for missed appointments ("no shows") and failure to attend appointments as scheduled may result in a discharge from care. _____ *Patient Initials*

*Date*_____*Signed*_____ *Printed Name*_____

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) 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" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

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. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician 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, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500. **Other Permitted and Required Uses and Disclosures** will be made only with your consent, **authorization** or opportunity to object unless required by law. **You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Please complete the back of this form →

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice may from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the following Acknowledgment Form. Please note that by signing below you are only acknowledging that you have received or given the opportunity to receive a copy of our Privacy Practices.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

Today's Date _____

Patient Name: _____ **Date of Birth:** _____

Patient Signature/Legal Representative_____

Relationship to Patient _____

Person Authorized to Speak with about Account and/or Personal Health _____

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgment of the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Intials: _____ Reason: _____