Kent Station Chiropractic & Massage

417 Ramsey Way Suite #113 Kent, WA 98032
Ph:253-859-0100 Fax:253-373-9600
Dr.Roger L. White

First name:_____ Last name:_____ Birthdate_____/_____/_____

SSN:_____ Marital status: Single / Married / Other

Address:_____ City:_____ State:_____ Zip code:_____

Home #:_____ Cell #:_____ Work #:_____

Email:_____ Employer:_____ Occupation:_____

Race (Please Circle Only One): American Indian or Alaska Native African American Asian

Hispanic or Latino Native Hawaiian or Other Pacific Islander Caucasian

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Preferred Language:_____

Height:_____Ft._____In Weight_____lbs.

Do you currently smoke? Yes or No Previous Smoker? Yes or No If yes, how long? _____

Blood Pressure _____

The reason for this visit: __Work __Sports __Auto accident __Trauma __Chronic

Please describe location and type of pain:_____
When did the condition began:_____/_____/_____
Does it interfere with: __Work __Sleep __Daily routine
Have you had similar conditions in the past? __YES __NO
Have you been treated for this in the past? __By medical doctor __Chiropractor
List any medications you are currently taking:_____
Dose:_____ Route: (oral, Injection) (Liquid Capsule Tablet)_____
Frequency:_____
Allergies:_____
Previous surgeries:_____
Past serious accidents:_____
Do you take supplements or vitamins? __YES __NO
Do you exercise? __YES __NO
Are you wearing any of the following: __Heel lifts __Sole lifts __Arch support How old is your mattress?_____

For woman: Are you pregnant? __YES __NO Taking birth control? __YES __NO

Referred by:_____

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Insurance Information

Primary insurance:_____
Insured ID #:_____ Group #:_____
Insured's name:_____ Birthdate_____/_____/_____

Secondary insurance:_____
Insured ID #:_____ Group #:_____
Insured's name:_____ Birthdate:_____/_____/_____

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other agreements have been made. I further authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical benefits to the above named physician or healthcare provider for services rendered.

Signature:_____ **Date**:_____/_____/_____

__Adult patient __Parent or guardian

The Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA) concerns the security of your personal and medical information. We respect your privacy and rights, so we follow these guidelines as applicable to our practice.

An explanation of our HIPAA policies is posted in the waiting room. I have been offered a copy of the form and I may read it or ask to take one home, if need to.

I certify that the above information is true and correct to the best of my knowledge. I hereby consent to the release of my confidential medical and patient information in the possession of the practitioner named above to other health care professionals to whom I am referred and to the insurance carrier or other entity responsible for payment, utilization, and/or quality review for all or a portion of my care and treatments and I authorize payment of medical benefits to the above name provider for services described.

_____
Printed Name

_____ _____
Signature **Date**

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Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is the science and art which concerns itself with the relationship between structure (primarily the spine) and the function (primarily the nervous system) as the relationship many effect the restoration and preservation of health. Health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine. Adjustments are usually done by hand, but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfactions. The benefits, risks, and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____ _____

Print name **Signature** **Date**

Consent to evaluate and adjust a minor child:

I,_____being the parent/legal guardian of_____
have read and fully understand the above informed consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.
Date of last menstrual cycle:_____

_____ _____

Signature **Date**

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OFFICE POLICIES

1. Please be on time for your appointment. Being late or last minute cancellations will cause severe scheduling disruptions, which can interfere with the quality of care you and other patients receive.
2. Please do not wear strong perfumes or colognes. We see many patients with allergies or respiratory problems. Strong scents can impair their progress.
3. Continued cancellations or missed appointments may result in being released from care. If you need to re-schedule an appointment, please call within 24 hours of your scheduled appointment.
4. Children are welcome here as patients. If you bring children with you for your appointment, you are responsible for their actions at all times. Our staff will assist you with your well-behaved children.
5. We may schedule you for multiple appointments. This will help insure convenient appointment time for you, as well as provide you with the highest level of care possible.
6. If you need to spend extra time discussing your health concerns with your doctor, please let our staff know, so we may schedule your next appointment accordingly.
7. Please notify your doctor of **any** changes in your health status, regardless of the significance.

FINANCIAL POLICIES

1. We accept the following forms of payment: Cash, personal checks, debit cards, Visa and Master Card.
2. **Payment is expected at the time of the visit**.
3. **We will bill your primary insurance company for care as a courtesy to you**.
4. **The patient is always responsible for the payment of their care. An insurance contract is between the patient and the insurance company.**
5. **Insurance coverage is never guaranteed**. If there are any problems between the insurance company and the patient, the latter may file a grievance directly with your insurance company**. Your signature below assigns assignment to this office for collection of benefits and also authorizes this office to release daily chart notes when necessary for the processing of claims.**
6. The office manager may approve account balances. Active monthly payments are required. **Accounts with balances 30 days past due may be charged a service fee of 12% per year compounded monthly.**
7. Any account where **no payment has been received for sixty days may be sent to a third party collection agency.** Any additional collection fees will be the responsibility of the patient. **NSF checks or rejected credit card payments will be charged a service fee of $35 per occurrence.**
8. We do offer a ***time of service discount*** when services are paid in full at the time of the visit. This discounted amount will not be passed on to your insurance company.
9. In some cases, we may have a contract with your insurance company governing how we handle your account. This contract may prevent us from offering you our *time of service discount*. Please ask us if you have any questions regarding this.
10. Please feel free to ask us any financial questions you may have. Our intent is to provide you with the highest level of service as well as care.
11. Your insurance company determines benefits when they receive our billing. **Any statements made by our staff regarding your coverage in no way guarantees that your care here will be covered by your insurance company, and you will be responsible for your account, regardless of insurance.**

By signing below, I acknowledge that I understand the policies as contained herein.

Patient or guardian:_____ Date: _____/_____/

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417 Ramsey Way Suite #113 Kent, WA 98032 (253)859-0100
Jessica Banks-Frazee, LMP

Massage Therapy Policy

Massage therapy is provided by appointment only. The room and block of the therapist's time is reserved for the patient and cannot be easily rescheduled without adequate notice.

If you cancel your massage therapy session please give at least 24 hours notice or a cancellation fee of $35.00 will be applied.

If you are late for your massage therapy appointment, you will receive the remainder of your session and be charged for the full session.

Thank you for your kind consideration of this important matter.

I understand this policy and will abide by it.

_____
Printed Name

_____ _____
Signature **Date**