Kirkland/Bellevue PrimeSpine Chiropractic & Massage Therapy

Full Legal Name: ____________________________ Date of Birth:_________________________

Preferred Name: ________________________ Gender: _________________________________

Address: (**including City/State/Zip**)____

Primary Phone Number: _____________________________ Text Reminders: Yes **or** No

Email Address: ____

Emergency Contact Name and Phone Number: _______________________________________

Occupation:____________________ Referred By:: ____________________________________

Current Medical Conditions/Complaints: ____

____

Current Medications (including blood thinners): ______________________________________

____

Major Surgeries/Injuries (past/future) :____

____

Health Insurance Name and Member ID*: ____

** Chiropractic treatment only. We do **NOT** accept health insurance for massage. Payment is due at time of service.**

Minor Consent (If applicable) I authorize Dr.Baker/Dr. Kelley and/or the massage therapist(s) to administer care, as deemed necessary.

Parent Name: ______________________________Signature: ____________________________

Is this related to a car accident/work injury? __Y/N_ Date of Injury: __________________

Insurance Company: _________________________Claim #: __________________________

Claim Manager Name, Phone, Email: ____

Attorney:____

(MVC) Third-Party Insurance Name: ____

Claim Manager Name, Phone, Email: ____

Attorney Name, Phone, Email:____

**If there is no personal injury protection and/or if the claim is not open/available we require health insurance & payment. 3rd party claims are required to pay at time of service*

I confirm that the information I provided is true and accurate to the best of my knowledge

Signature and Date: ____

Acknowledgment of Receipt of Privacy Practices (HIPAA)

I understand that as part of my health care, Washington Health Associates originates/maintains paper and/or electronic records describing my health history and treatment plans. I understand that this information serves as a basis for planning my care and treatment, communication among the health professionals who contribute to my care, information for applying my diagnosis and treatment information to my bill, a means by which a third-party payer can verify that services billed were actually provided, and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals. I understand that I have the following rights and privileges: to review this notice prior to signing, to object to the use of my health information for directory purposes, and to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations. I understand that Washington Health Associates Is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations. I further understand that Washington Health Associates reserves the right to change its notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. I wish to have the following restrictions to the use or disclosure of my health information: I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

Workers Compensation

Washington Health Associates will bill your ***open, approved*** claim. Please be advised that in the event your claim is denied you are financially responsible for all charges. If you are receiving treatment at another facility at the same time you are being treated with Washington Health Associates, you are responsible for tracking your authorized visits. In the event you exceed your authorized visits as a result of treatment at another facility, you will be financially responsible. If the claim is not open/allowed for billing or the transfer of care has not been approved, your private health insurance does not cover any treatments, any remaining balance will be your responsibility.

Motor Vehicle Collision

Washington Health Associates will bill my insurance company on my personal injury protection and/or medical payment coverage, if available. **If coverage is not available (or if you exhaust your benefits)**, we require health insurance and then payment at the time of service. *Patients without PIP and/or exhausted PIP and without medical coverage are required to pay a portion of treatment upfront, the remaining balance that is owed is paid when the patient receives their settlement after the treatment is finished.* We will go over the payment plan details with you if you do not have any coverage.

Insurance Policy

I hereby assign all medical benefits to which I am entitled to Washington Health Associates in the event they file insurance on my behalf. I understand that Washington Health Associates strongly encourages me to verify my benefits with my insurance company. Should I decide not to check my benefits, I understand that any fees accrued with that insurance company that does not pay will be my responsibility. I understand that I am financially responsible for all charges whether or not processed/paid by insurance. As a courtesy to you, we will verify and get a quote of your benefits then go over your benefit details on your first or second visit. It is the patient's responsibility to track any visit limits through their insurance carrier. **All payments are due at the time of service.**

Massage Policy

Effective 1/1/23: Our office requires a card on file to hold future appointments.

We are happy to reschedule your appointments; however, when a conflict occurs our policy requests a 24-Hour notice from the time your appointment is scheduled to cancel. *We have zero tolerance for no-shows* if you fail to attend your scheduled appointment and do not provide us with the appropriate prior notification ***you will be automatically charged a fee of $45.*** This fee is not billable through your insurance and you will not be able to schedule another appointment until this fee is paid. You will be banned from scheduling future appointments and will be able to schedule on a same-day basis only. If you fail to show and/or communicate to our office for two consecutive sessions, we will consider you discharged from our care and we will cancel all scheduled appointments going forward.

I have read and fully understand the above statements, and accept the terms of this consent. All questions regarding the doctor’s/massage therapist(s) objectives pertaining to my care in this office have been answered to my complete satisfaction. I, therefore, accept Chiropractic/Massage therapy care on this basis.

Patient/Parent Signature: ____ Date: _______________________