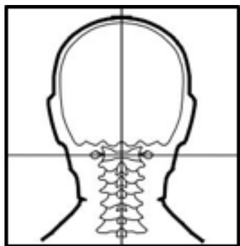
Patient Name ___________________________



Atlas Spinal Care, P.C.

16500 SE 15th Street, Suite 160
(360) 718 - 7944 Vancouver, WA 98683 Fax (360) 718 - 7931

Patient Information

Name: ____

Address: ____

____

Birth Date ___/___/___ Age ____ Male ___ Female ___

Social Sec. # ____/____/_____

Occupation ______________________________

Employer ______________________________

Marital Status: ______________ # of children ______

Home # _______________ Work # ______________

Cell #______________ Email: ___________________________

Best way to contact: ________________________________

Who may we thank for referring you?

____

Insurance

Who is responsible for this account?____________________

Relationship to patient? ______________________________

Primary Insurance Company___________________________

ID #______________________ Group #___________________

Primary Policy Holder __________________________________

Birth Date _____/_____/_____

Secondary Insurance Company ________________________

ID #_____________________ Group# ______________________

Primary Policy Holder: __________________________________

Emergency Contact

Name:_________________ Relationship: ________________

Home #_____________________ Cell #_________________

Patient Condition

What is your major symptom/problem?_____________________________________

When did your symptoms begin? ____

Have you had this problem before? ______________________________________

Is your condition getting progressively worse? Yes _______ No ________

Is this problem: Constant _____ Comes & Goes _____

How does it feel? Burning ___ Sharp ____ Shooting ___ Dull ____ Ache _____

Stiff ___ Tingling ___ Throbbing ___ Swelling ___ Other ________________

Circle the severity of your pain (no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

What makes your condition better? __________ What makes your condition worse?

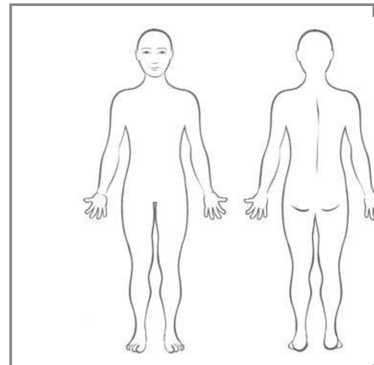
____

Does it interfere with: Work ____ Sleep ___ Daily Routine ___ Recreation ___

Activities/movements that are painful to perform: Sitting ___ Standing ___ Walking ___ Bending ___ Lying Down ___

Driving ___ Reading ___ Other _________________________

PLEASE MARK WHERE IT HURTS



Patient Name ___________________________

MASSAGE HEALTH HISTORY

What other treatments have you had for this condition?

__Chiropractic __ Physical Therapy __Neurologist __ Medication __ Surgery __ Orthopedic

Other:___________________________________

List any allergies you currently have (food, medication, etc): ____

____

List any medications you are currently taking: ____

____

List any vitamins/herbs/minerals you are currently taking: ____

____

Previous surgeries & dates: ____

Broken bones & dates: ____

Falls/Injuries & dates: ____

What is your method of exercise and stress relief? ____

Circle any of the following conditions you have had:

Earache	Epilepsy/Seizures	Anxiety/Depression	Arm/Shoulder Pain
Arthritis	Asthma	Bladder Problems	Cancer
Chronic Fatigue	Deafness	Diabetes - Type 1 / Type 2	Digestion Problems
Ear Ringing	High Blood Pressure	Headaches/Migraines	Heart Disease
Hepatitis	Herniated Disc	Insomnia	Kidney Problems
Leg Pain	Neck Pain	Mid-Back Pain	Low Back Pain
Osteoporosis	Poor Circulation	Prostate Issues	Rheumatoid Arthritis
Sciatica	Scoliosis	Shingles	Sinus Infection

Are there any areas you *DO NOT* want massaged?

Abdomen __ Buttocks ___ Thighs ___

Other ____

What type of pressure do you prefer?

___ Light ___ Moderate ___ Deep ___ Not Sure

*****INTRA ORAL MASSAGE ONLY*****

Are you currently wearing dentures or bridge? Y / N

The statements made on this form are accurate to the best of my knowledge and I agree to massage at Atlas Spinal Care for treatment of my symptoms.

Patient Signature _________________________________ Date ___________

Patient Name ___________________________

Atlas Spinal Care, P.C.

INFORMED CONSENT FOR MASSAGE THERAPY

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation; relief of muscular tension, spasm or pain; or for increasing circulation or energy flow. If I experience any pain or discomfort during the session, I will IMMEDIATELY INFORM the practitioner so the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see my primary health care provider or other qualified medical specialist for such services. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe pharmaceuticals, or treat any physical or mental illness. I affirm that I have stated all my known medical conditions and answered all my questions honestly and completely. I understand any sexual misconduct will not be tolerated and the massage will be terminated immediately. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioners part should I forget to do so.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the above-named procedures. I intend for this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Patient Name (Printed) ____

Patient Signature ____ Date: ________________

(Or Patient Representative) (Indicate relationship if signing for patient)

Patient Name ___________________________

Atlas Spinal Care, P.C.

FINANCIAL & OFFICE POLICIES

Please be on time for your appointment. Being late or last minute cancellations can cause severe scheduling disruptions which can interfere with the quality of care you and other patients receive.

Please do not wear strong perfumes/colognes. We see many patients with allergies or respiratory problems. Strong scents can impair their progress.

We understand that unanticipated events happen occasionally. In our desire to be effective and fair to all of our clients and out of consideration for our therapists time, there will be a **$35 CANCELLATION FEE** if you are unable to provide a **12 hour advance notice** and we are unable to fill your spot; or no-show more than one time. This cancellation fee must be paid in full prior to your next scheduled treatment. Continued cancellations or missed appointments may result in being released from care. If you need to re-schedule an appointment, please call within 12 hours of your scheduled appointment.

INSURANCE WILL NOT COVER CANCELLATION OR NO SHOW FEES, INCLUDING AUTO ACCIDENT INSURANCE.

Anyone who is not present for the scheduled session during the first 20 minutes will be considered “no show”. Anyone who is late and has notified us will have the option to receive a massage for the remaining time of the appointment. Regardless of the length of the treatment, charges will be for the full session.

We accept the following forms of payment: Cash, Personal Checks, Debit Cards, Visa, Discover, American Express and Master Card.
There will be a 3% service fee for all payments made on a credit or debit card over $1,000.

Payment is expected at the time of your visit. We will bill your primary insurance company for Initial Intensive Care as a courtesy to you. The patient is always responsible for the payment of their care. An insurance contract is between the patient and their insurance company.

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.

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.

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.

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.

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

Your insurance company determines benefits when they receive our billings. 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: ____/____/____

Patient Name ___________________________

Atlas Spinal Care, P.C.

Patient Confidential Communication

Patient Name:__________________________________ DOB: ___________________________

The Health Insurance Portability and Accountability Act (HIPAA) gives you the right to request that we communicate financial and/or medical information to you in confidence by a particular method. In order to protect the privacy and confidentiality of your information, please complete the following. This will tell us how you wish to be contacted and with whom we may discuss your health care.

You may contact me at the following phone numbers: (Provide all that apply)

Home Phone: ____________________ Cell Phone: _____________________ Work:____________________

____ Yes, you may leave a confidential message at: Home: ___ Cell: ___ Work:___ (Check all that apply)
____ Yes, you may leave the minimum necessary information on my answering machine or voice mail listed above.
____ Yes, you may provide Billing Information: _____ ; Treatment Information: _____; and Scheduling Information: _____ to the individual(s) listed below:

Name:_____________________________ Relationship: _____________________________

Name:_____________________________ Relationship: _____________________________

Our office will continue to communicate with you according to your above response(s) until you change your preferences. You may do so by completing a new form. By signing below, you grant permission to the communication outlined above.

__________________________________ __________________________________
Signature of Patient/ Personal Representative Date

Notice of Privacy Practices Acknowledgement

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Atlas Spinal Care.

Our Notice of Privacy Practices describes in more detail how your health history information may be used and disclosed, and how you can access your information.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

__________________________________ __________________________________

Signature of Patient/ Personal Representative Date

__________________________________ __________________________________
Printed name if signed on behalf of patient Relationship to patient (parent, legal guardian, etc)

Patient Name ___________________________

Atlas Spinal Care, P.C.

Notice of Privacy Practices

Patient Name: __________________________________ DOB:________________________________

This is an abbreviated Privacy Statement. Please see the front desk for a complete Privacy Statement.

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at this office. We need this record to provide you with the highest quality of care and to comply with local, state, and federal laws. This notice will tell you about the ways we may use and disclose your medical health care information. We also describe your rights and duties we have regarding the use and disclosure of your medical information.

Law requires us to:

- Keep your medical information private
- Make this notice available to you describing our legal duties, privacy practices, and your rights regarding your medical information.
- Follow the terms of the notice that is now in effect.

We have a right to:

- Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
- Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of changes to privacy practices:

- Before we make any important changes in our privacy practices, we will change this notice and make the revised notice available at our office upon request.

Use and disclosure of your medical information are as follows: treatment, payment, or healthcare operations; appointment reminders; disaster relief; fundraising; research; funeral director, coroner or medical examiner; specialized government functions; court order, judicial and administrative proceedings; public health activities; victims of abuse, neglect, or domestic violence; workers compensation; health oversight activities; and law enforcement. In all cases, we will release only the minimum amount of information necessary.

You have a right to look at or get copies of your medical information; receive a list of our business associates; receive a list or accounting of disclosures; request that we place additional restrictions on disclosure; request that we communicate with you by different means or to different locations; request that we change your medical information.

If you have any questions about this notice or if you think we may have violated your privacy rights, please contact our privacy officer. You may also submit a written complaint with the U.S. Department of Health and Human Services. The address is 200 Independence Avenue, S.W., Washington, D.C. 20201. You can call toll-free at 1-877-696-6775. We will not retaliate in any way if you choose to file a complaint. **Note: This authorization may be revoked at any time by giving a written notice to Atlas Spinal Care. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization.**

____ _____________________________________ Patient

Signature / Personal Representative Date