EASTLAKE CHIROPRACTIC AND MASSAGE CENTER, PS

Patient Registration

Patient: _____ Date of Birth _____ Today's Date _____

Gender: _____ Preferred Pronouns: _____

Address: _____ City, State, Zip: _____

Phone # (____)_____ Work Phone # (____)_____ Ext_____

Whom may we thank for referring you to our office? _____

Occupation: _____ Employer: _____

Marital Status: ☐ M ☐ S # of Children ____ages_____ Spouse/Partners Name:_____

In case of emergency, notify _____ Relationship_____

Address: _____Phone # (____)_____

Medical Doctor Name: _____ Clinic Name:_____

Address:_____ Phone # (____)_____

INSURANCE: PLEASE SUPPLY INFORMATION FOR BOTH INSURANCE CARRIERS IF APPLICABLE

Is this an: ____ Auto Accident? _____ Work Related? ____ Other? Date of Injury: _____

Primary Carrier Name: _____ Secondary Carrier Name:_____

Phone # (____)_____ Policy/Claim #_____ Phone # (____)_____ Policy/Claim #_____

Insured: _____ DOB _____ Insured: _____ DOB _____

ID #:_____ Group #_____ ID #:_____ Group #_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I also understand and agree that all services rendered me are charged to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered me will be immediately due and payable. I hereby agree that I will be assessed one percent (1%) charge per month on any fee not kept current.

Patient or Guardian's Signature: _____ Date: ____/____/____

EASTLAKE CHIROPRACTIC AND MASSAGE CENTER, PS

WHICH OF THE FOLLOWING HAVE YOU BEEN EXPERIENCING DIFFICULTY WITH OR BEEN DIAGNOSED WITH: (PLEASE CHECK ALL THAT APPLY)?

___HEADACHES
___NECK PAIN
___NECK STIFFNESS
___BACK PAIN
___BACK STIFFNESS
___DISC PROBLEMS
___SHOULDER PAIN
___ARM PAIN
___ELBOW PAIN
___WRIST PAIN
___HAND/ FINGER PAIN
___TINGLING IN ARM/HAND
___COLD HANDS
___HIP PAIN
___LEG PAIN
___KNEE PAIN
___ANKLE PAIN

___FOOT/ TOE PAIN
___TINGLING IN LEGS/ FEET
___COLD FEET
___SWOLLEN ANKLES
___PAINFUL JOINTS
___ARTHRITIS
___NIGHT PAIN
___EXCESSIVE FATIGUE
___POOR DIET
___FAINTING
___NAUSEA
___NERVOUSNESS
___FREQUENT COLDS
___SINUS PROBLEMS
___ALLERGIES
___ASTHMA
___EAR INFECTIONS

___STOMACH PROBLEMS
___SWALLOWING
___CONSTIPATION
___DIARRHEA
___ABNORMAL STOOLS
___PAINFUL BOWEL MOVEMENTS
___KIDNEY PROBLEMS
___BLADDER PROBLEMS
___PROSTATE PROBLEMS
___MENSTRUAL PROBLEMS
___GALL BLADDER PROBLEMS
___LIVER PROBLEMS
___CHEST PAINS
___HIGH BLOOD PRESSURE
___LOW BLOOD PRESSURE

___HEART PROBLEMS
___HEART ATTACK/ DISEASE
___STROKE
___DIABETES
___ANEMIA
___THYROID PROBLEMS
___OSTEOPOROSIS
___CANCER
___DIZZINESS/VERTIGO
___BALANCE PROBLEMS
___COORDINATION PROBLEMS
___VISION PROBLEMS
___DEPRESSION

ANY CONDITION/CONCERN NOT LISTED ABOVE_____

Have you had any significant trauma in the past (auto accidents, sports injuries, falls, etc.): Y / N
If yes, give description / date of each:_____

_____

List any operations and dates of each:_____

List any diseases and dates of each:_____

Are you presently taking any medication: Y / N Is it for your current problem: **Y / N**
List any name(s), dosage and reason you are taking medication:_____

_____

Do you have any medication allergies? Y / N If yes, What?:_____

EXERCISE: ___ NEVER ___ LIGHT (1-2X per week) ___ MODERATE (3-4X per week) ___ INTENSE (5+X per week)

Types of exercise :_____

SMOKING STATUS: Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked
ALCOHOL STATUS: Every Day Drinker / Occasional Drinker / Former Drinker / Never Drank
RECREATIONAL DRUGS: Y / N WHAT AND HOW OFTEN?_____

RATE YOUR TYPICAL STRESS LEVEL (OVERALL): 1 2 3 4 5 6 7 8 9 10+
MILD MODERATE SEVERE DISABLING

HAVE ANY OF YOUR BLOOD RELATIVES BEEN AFFECTED BY THE FOLLOWING CONDITIONS: (Indicate which family member. For example: Father, mother, grandmother, grandfather, aunt, uncle, etc.)

_____RHEUMATOID ARTHRITIS _____HEART DISEASE _____HIGH BLOOD PRESSURE
_____ STROKE _____DIABETES _____CANCER
OTHER_____

What is your height and Weight? Height: ___/___ ___ Weight:_____ lbs

I have read and reviewed the information herein and represent that the same is true, correct and complete. I understand that the doctor is relying upon the information in rendering treatment.

Patient signature_____ Date:___/___/_____

EASTLAKE CHIROPRACTIC AND MASSAGE CENTER, PS

UNDERSTANDING INSURANCE BILLING

THIS IS IMPORTANT, PLEASE READ THOROUGHLY AND ASK ANY QUESTIONS YOU NEED BEFORE INITIALING AND SIGNING.

Insurance can be a complicated affair. We want to spare you any surprises if we can. It is our hope to never have a bill come between us. Here are some important things to know about insurance companies:

1. **Your insurance company only pays for care that *they* feel is "medically necessary". Your insurance co. also dictates that your care must reduce or eliminate symptoms of an acute (sudden) condition; or a sudden exacerbation of a chronic condition. In both circumstances, there is often a specific injury to address.**

   Initial: _____

For example, although daily computer or yard work does cause aches and pains, your insurance co. **does not** consider these activities to be injurious for which they will pay for care on an **on-going basis, week after week, month after month.** However, if you reached for a file or lifted something heavy and felt a pain in your back or neck at that moment, your insurance co. **does** consider that to be a payable "event" and may approve an extended treatment plan for you to get well.

The best thing you can do to have your claim covered is to tell your provider how you are improving (or not) based upon your daily activities:

1) Can you sit with less pain?
2) Can you walk for longer periods?
3) Can you pick up your kids?
4) Can you do your workouts? Work in the yard? Paint? Type? Etc, etc.

2. **For massage,** to further prove medical necessity, **a prescription/referral is required from a chiropractic or medical doctor.** If you are seeing one of our chiropractors, he can write one for you. Minimally, our chiropractors would need to examine you first.

   Initial: _____

3. **Massage and physical therapy (PT) are often a combined benefit where your** insurance allows a limited number of covered visits per year. For example, they may allow 12 visits/year for the above therapies. This is important to note because **your chiropractor will always include physical therapy procedures as part of your visit.** It is considered **PT** when the chiropractor stretches, tractions, mobilizes, massages, uses heat or ice, or works the muscles before or after the actual adjustment of the spine.

These procedures are billed separately as PT and therefore credited to your annual PT benefit when submitted to your insurance company.

If you do not want us to bill your insurance and want to keep your PT credits for future use, a fee of $11 will be due at time of service.

Initial: _____

4. **Medicare (for reasons we do not agree with) will not cover examinations ($85) or x-rays ($85).** Examinations are required to prove medical necessity. Your supplemental insurance will also not cover these services. If you have a secondary insurance policy, they may cover these services.

   Initial: _____

5. As a courtesy to you, we will contact your insurance co. and ask what your benefits are in relation to chiropractic, massage, physical therapy, x-rays, and orthotics. **The benefits that we relay to you are dependent on what we are told by your insurance company. Unfortunately, sometimes their representatives give us incorrect information, so we STRONGLY suggest that you familiarize yourself with your plan.** Ultimately treatment is your financial responsibility, so again, we strongly suggest that you call your representative.

   Initial: _____

6. **Cancellation policy for massage**: We require 24 hours notice for cancelling or rescheduling a massage appointment. Your consideration for other patients and your massage therapist is appreciated. **Monday appointments must be cancelled/rescheduled by the Friday before. Failure to provide 24-hour notice or not showing will result in a $75 fee. This is not covered by insurance.** If you are running late for your massage or chiropractic appointment, please call, we will do our very best to still see you.

   Initial: _____

7. **Acknowledgement of receipt of Notice of Privacy Practices:** I acknowledge that I have had an opportunity to read and receive a copy of Eastlake Chiropractic and Massage Center (ECC) "Notice of Privacy Practices". This notice describes how ECC may use and disclose my protected health information, certain restrictions on the use and disclosure of healthcare information and rights I may have regarding my protected health information.

   Initial: _____

I acknowledge that I have read and understand the above statements.

Signature _____ Date _____

Print Name _____

Eastlake Chiropractic and Massage Center, PS

MASSAGE THERAPY

INFORMED CONSENT FORM

This record of consent is required before the first assessment or treatment and will be maintained confidentially in the client file. It may only be released to a third party with prior written consent of the client.

Massage Therapy includes the assessment and treatment of the soft tissues and joints of the body, using soft tissue manipulation, joint mobilization, remedial exercises and self-care programs as determined by the therapist.

By signing below, the client agrees to the following:

- All massage treatments, information and records will be kept confidential and securely stored for use only by my massage therapists.
- Written consent must be given by me prior to any disclosure or sharing of my personal and clinical information with any third party.
- Privacy will be assured as I have the right to undress only to my comfort level and according to the requirements of the treatment.
- Draping will be used by the therapist as required to expose only those parts of my body that require treatment and/or as I choose to ensure my comfort during treatment.
- During treatment, the therapist will endeavor to work such that a pain level of 6-7 is not exceeded, based on a pain scale of 1-10.
- If at any time during the treatment, I feel uncomfortable with the treatment for any reason, I have the right to request an immediate stop to the session or request modifications to the treatment, regardless of prior consent given.
- Promptness is expected for all appointments. In the event of lateness, the massage may be cut short due to other commitments of the therapist. Fees will be maintained per the schedule.
- Cancellation of any appointment must be received at least 24 hours in advance; otherwise, a $75 fee will apply.
- Fees for treatment are due prior to departure on the day of the treatment. Cash or personal checks are accepted.
- The therapist may refuse to treat any client or part of their body with just and reasonable cause.

I, _____ (PRINT NAME), have read and understood the information above and consent to the massage treatment for the condition discussed with my therapist today.

Date: _____

Client Signature: _____