Martha Lake Chiropractic & Wellness

Confidential Patient Information

Please print clearly.

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: ____/____/_____ Male ☐ Female ☐ SSN: _____ - ____ - _____

Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐ Domestic Partner ☐

Mailing Address _____

City _____ State _____ Zip _____ Work Phone: (____) ____ - _____ Ext ____

Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____ Carrier _____

Email: _____

When checking in on our kiosk which number would you prefer to check in with?

Home ☐ Cell ☐ Work ☐ Password ☐

Emergency Contact Info: Name: _____ Phone: (____)____-_____

Are your symptoms related to a motor vehicle accident or a work injury? ☐ Yes ☐ No

Date of Injury _____/_____/_____

Insurance Information:

Please provide the front desk with your insurance card. If you have secondary insurance coverage please inform front desk.

Name of insurance: _____ Subscribers Name:_____

Subscribers birthdate____/____/_____ Relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance Information:

Name of insurance: _____ Subscribers Name: _____

Subscribers birthdate____/____/_____ Relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Authorizations:

I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits of Martha Lake Chiropractic / Dr. Lawrence Ball

I authorize payment of any medical benefits from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

I understand and agree the health and accident policies are an arrangement between my insurance carrier and myself. Furthermore, I understand that paid directly to this office will prepare any necessary reports and forms to assist me in making collection from insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly 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 products or professional services rendered will be immediately due and payable.

Patient Signature: _____ **Date:** ____/_____/_____

Guardian Signature: _____ **Date:** ____/_____/_____

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Financial and No-Show Policy

Insurance Patients
We will bill your insurance company accordingly. Please understand that services are rendered to you and not the insurance company. In the event the insurance company denies the claim or authorization for any reason, including medical necessity, all services provided to you through our office will be your financial responsibility. If you have a deductible with your insurance company, we will bill you. We reserve the right to deny services if you fail to pay your outstanding balance

All copays, deductibles, coinsurance, and time of service payments are due at the time of service.

Paying Out of Pocket
Payment for ALL services or supplies is due at the time of service.

Making Payments
You may pay by cash, credit/debit card, or check. There is a $30.00 charge for all returned checks. We accept VISA, MasterCard, Discover, American Express, and Care Credit.
Any outstanding balance over 30 days may be subject to 12% interest per annum.

Cancelation/No-Show Policy
If you are unable to make it to your appointment it is important for you to call to cancel or reschedule your appointment time. For any **chiropractic** appointment you do not show up to or cancel less than **4 of our business hours** prior to the start of your appointment time, you will be charged a **$60.00 fee** for an adjustment or a **120.00 fee** for an exam. For any **massage** appointment you do not show up to or cancel less than **24 hours** prior to the start of your appointment time, you will be charged a **$80.00 fee**. This must be paid before your next appointment.

Initial: _____

Showing Up Late
If you anticipate you will be late for your appointment, please call us and let us know. Depending on how late you arrive, we will determine if we will be able to get you in or you may be subject to **the late/cancelation/no-show fee** as stated above. We want to be as efficient as possible and when you run late it makes the doctor run late and other patients who are on time wait longer.

Please arrive 10 minutes prior to your appointment to allow time to check in unless otherwise instructed.

By signing below, you are acknowledging that you have read, understand, and agree to all of the information on this form.

Print Name: _____

Signature: _____ **Date:** _____

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Dr. Mark L Barrett, DC Dr. Lawrence Ball, DC Dr. Peter Lind, DC
125 164th St. SE Bothell, WA 98012 I Phone (425)-745-2311 Fax (425)-745-2988

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 understand 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 a science and art which concerns itself with the relationship between structure (primarily of the spine) and function (primarily the nervous system) as that relationship may 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 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 the specific adjustments of the spine.

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 satisfaction. 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 treat a minor:

I, _____, being the parent or guardian of

_____ have read and fully understand the above Informed Consent and

hereby grant permission for my child to receive chiropractic care.

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Acknowledgement of Receipt of HIPAA Privacy Practices

By signing this form, I acknowledge that I have received a copy of the **Martha Lake Chiropractic Center** Patient Notice of Privacy Practices effective May 02, 2016. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the health care of providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and accreditations.

Patient Name: _____

Signature: _____ Date: _____
(or Guardian, if applicable)

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the Acknowledgment
- ☐ An emergency situation prevented us from obtaining Acknowledgment
- ☐ Other (Please Specify): _____

_____

Staff signature: _____ Date: _____