Julie L.B. Door, LMP
Willows Chiropractic Clinic & Therapeutic Massage
2401 South Meridian Street * Puyallup, WA 98373
(253) 841-6482 Fax (253) 864-0148

CLIENT HEALTH INFORMATION

Patient Information

Name: _____

Address _____

City _____ State _____ Zip _____

Phone: Home ( )_____ Cell ( )_____

Employer: _____ Work ( )_____

Address _____

City _____ State _____ Zip _____

Date of Birth: _____ Gender: ☐ M ☐ F

Maritial Status: ☐ Single ☐ Married ☐ Divorced

Social Security #: _____ (Required for insurance claims)

Spouse's Name: _____

EMERGENCY CONTACT: _____

Phone: Home ( )_____ Cell ( )_____

Work ( )_____

Primary Health Care Provider

Name: _____

Address _____

City _____ State _____ Zip _____

Phone: ( )_____ Fax# ( )_____

Injury Information

Required for Insurance / MVA / Worker's Compensation

Date of Injury / Onset: _____

Employment Related: ☐Yes ☐ No

Motor Vehicle Accident: ☐Yes ☐ No

Attorney's Name: _____

Law Firm: _____

Address _____

City _____ State _____ Zip _____

Phone: ( )_____ Fax# ( )_____

Current Health Concerns

Please list all medications you are currently taking:

_____

_____

What condition(s) brought you to our office today?

Primary: _____

Are the symptoms: ☐ Mild ☐ Moderate ☐ Disabling

☐ Constant ☐ Intermittent ☐ ↑ w/activity ☐ ↓w/activity

☐ Getting better ☐ Getting worse ☐ No change

Secondary: _____

Are the symptoms: ☐ Mild ☐ Moderate ☐ Severe

☐ Constant ☐ Intermittent ☐ ↑ w/activity ☐ ↓w/activity

☐ Getting better ☐ Getting worse ☐ No change

Insurance Information

PRIMARY CARRIER:

Insurance Carrier: _____

Address _____

City _____ State _____ Zip _____

Phone: ( )_____ Fax# ( )_____

ID / Claim #:_____ Group/Policy#_____

Required for claim submission:

Insured's Name: _____

Address _____

City _____ State _____ Zip _____

Phone: ( )_____ Date of Birth: _____

Insured's SS#: _____ Relationship_____

Employer: _____

Address _____

City _____ State _____ Zip _____

SECONDARY CARRIER:

Insurance Carrier: _____

Address _____

City _____ State _____ Zip _____

Phone: ( )_____ Fax# ( )_____

ID / Claim #:_____ Group/Policy#_____

HEALTH HISTORY Please check all boxes that apply

General Health:

Current	Past	
☐	☐	Headaches
☐	☐	Pain
☐	☐	Sleep Disturbances
☐	☐	Fatigue
☐	☐	Infections
☐	☐	Fever
☐	☐	Sinus
☐	☐	Other_____

Skin Conditions:

Current	Past	
☐	☐	Rashes
☐	☐	Athlete's Foot
☐	☐	Warts
☐	☐	Other_____

Muscles and Joints:

Current	Past	
☐	☐	Rheumatoid Arthritis
☐	☐	Osteoarthritis
☐	☐	Osteoporosis
☐	☐	Scoliosis
☐	☐	Broken Bones
☐	☐	Spinal Problems
☐	☐	Disk Problems
☐	☐	Lupus
☐	☐	TMJ, Jaw Pain
☐	☐	Spasms, Cramps
☐	☐	Sprains / Strains
☐	☐	Tendonitis
☐	☐	Bursitis
☐	☐	Stiff or painful joints
☐	☐	Weak or sore muscles
☐	☐	Neck / Shoulder Pain
☐	☐	Arm / Wrist Pain
☐	☐	Low back / Hip Pain
☐	☐	Leg / Knee Pain
☐	☐	Other: _____

Nervous System:

Current	Past	
☐	☐	Head Injuries
☐	☐	Dizziness
☐	☐	Ringing in Ears
☐	☐	Loss of Memory
☐	☐	Confusion
☐	☐	Numbness / Tingling
☐	☐	Sciatica
☐	☐	Chronic Pain
☐	☐	Depression
☐	☐	Other_____

Respiratory, Cardiovascular:

Current	Past	
☐	☐	Heart Disease
☐	☐	Blood Clots
☐	☐	Stroke
☐	☐	Lymphadema
☐	☐	High/Low Blood Pressure
☐	☐	Irregular Heart Beat
☐	☐	Poor Circulation
☐	☐	Swollen Ankles
☐	☐	Varicose Veins
☐	☐	Chest Pain / Shortness of Breath
☐	☐	Asthma
☐	☐	Other_____

Allergies:

Current	Past	
☐	☐	Scents / Oils / Lotions
☐	☐	Detergents
☐	☐	Other_____

Endocrine System:

Current	Past	
☐	☐	Thyroid _____
☐	☐	Diabetes _____
☐	☐	Other_____

Digestive / Elimination System:

Current	Past	
☐	☐	Bowel Problems
☐	☐	Gas / Bloating
☐	☐	Bladder / Kidney
☐	☐	Prostate
☐	☐	Abdominal Pain
☐	☐	Other_____

Reproductive System:

Current	Past	
☐	☐	Pregnancy _____
☐	☐	PMS
☐	☐	Painful Menses
☐	☐	Fibrotic Cysts
☐	☐	Other_____

Cancer / Tumors:

Current	Past	
☐	☐	Benign _____
☐	☐	Malignant _____

Habits:

Current	Past	
☐	☐	Tobacco _____
☐	☐	Alcohol _____
☐	☐	Coffee / Soda _____
☐	☐	Drugs _____

Surgeries: _____

Past Injuries: _____

Major Illnesses: _____

I, the undersigned, or designated representative for the patient, volunteer consent for care. I understand that no guarantees or promises are made concerning the outcome of treatment.

I hereby authorize Julie L.B. Door, LMP to consult with my health care provider(s) regarding my health and treatment. I authorize the release of my chart notes and progress reports to facilitate coordination of care and the referral process.

I authorize the release of any medical or any other information necessary to process this claim and I authorize payment of medical benefits directly to JULIE L.B. DOOR, LMP for services provided.

Signature: _____

Date: _____

Julie L.B. Door, LMP
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HIPAA Communication Requests

Patient Name: _____

I wish to be contacted in the following manner (check all that apply):

[ ] **Home Telephone #: ( ) _____**
- [ ] **O.K. to leave detailed message**
- [ ] **Leave message with call-back name and number only**

[ ] **Work Telephone #: ( ) _____**
- [ ] **O.K. to leave detailed message**
- [ ] **Leave message with call-back name and number only**

[ ] **Written Communication**
- [ ] **O.K. to mail to my home address**
- [ ] **O.K. to mail to my work/office address**
- [ ] **O.K. to fax to this #: ( ) _____**

[ ] **Cellular Telephone #: ( ) _____**
- [ ] **O.K. to leave detailed message**
- [ ] **Leave message with call-back name and number only**

[ ] **E-mail Address: (used for appointment confirmation, office closures, promotions)**

_____

[ ] **I authorize release of my patient billing account information to: _____**

Relationship to patient: _____ Expires: _____

[ ] **I authorize release of my appointment information to: _____**

Relationship to patient: _____ Expires: _____

****This office CAN NOT release your account balance, or your appointment date or time to anyone but you unless they are specifically listed on this form or present a valid release of information signed by you.**

I understand that I have the right to request changes to this communication request form. Any changes must be made in writing and a new form completed. This form remains in effect unless written notice is given by me.

I certify that I have received a copy of Willows Chiropractic Clinic & Therapeutic Massage's Notice of Privacy Practices.

_____ _____ _____

Patient Signature [ ] Guardian Signature [ ] **Patient Date of Birth** **Date Signed**

Julie L.B. Door, LMP
Willows Chiropractic Clinic & Therapeutic Massage

FINANCIAL POLICIES

The following are the financial polices for massage therapy in our office. Please initial the box next to the policy that you wish to use. Please be sure to read the policy carefully and make sure that you understand and agree to the policy prior to signing this document. Our staff will be happy to answer any questions you may have.

[ ] **NO HEALTH INSURANCE:** Payment is expected at the time services are rendered. For your convenience our office accepts VISA / MASTERCARD, checks and cash.

[ ] **HEALTH INSURANCE:** Since every health insurance policy is different, we do not know if your insurance policy will cover massage therapy. If your policy does allow for massage therapy, and our therapist meets their requirements for rendering services, we will be happy to submit your claim for you. Our staff is happy to verify your massage therapy benefits for you. However, it is imperative that you understand that we will be relaying to you the ***quote of benefits received from your carrier and that final payment determinations are made once the claim is received.*** All deductibles, co-insurances, and co-pays are due at the time of service.

[ ] **WORKER'S COMPENSATION:** All on the job injuries ***MUST BE REPORTED TO YOUR EMPLOYER AND A CLAIM MUST BE FILED*** with the Department of Labor & Industries, or your employer's self insured firm. If you were injured on the job you will need to have a referral from your primary care physician and care must be approved by your claims adjuster. If your claim, or massage therapy treatment, is not allowed by Labor and Industries you will be responsible for the payment of the services received in our office. In the event that your claim is denied by Labor and Industries, your financial policy will revert to the No Health Insurance policy listed above.

[ ] **MEDICARE:** Medicare does not cover massage therapy. Payment for services is expected at the time services are rendered.

MOTOR VEHICLE ACCIDENTS:

[ ]**PERSONAL INJURY PROTECTION:** If you were involved in a motor vehicle accident your automobile insurance policy may pay for your therapeutic massage services. Your treating physician(s) must authorize treatment and provide a written referral. If your personal injury policy does not cover your treatment, your policy limits are exhausted, or your carrier has suspended benefits, your claim will revert to a Third Party Claim or No Health Insurance Claim.

[ ]**THIRD PARTY CLAIMS:** In the event that you do not have Personal Injury Protection on your automobile policy, arrangements can be made to hold your bill until the time of settlement with the third party carrier. In order to receive treatment under a third party claim your treating physician(s) must authorize treatment and provide a written referral. You must sign a third party attorney's lien and have obtained legal representation from an attorney who will sign a third party attorney's lien. An auditor's lien may be filed against your claim with the Pierce County Auditor.

All accounts are subject to a $10.00 billing fee and Interest of 1% per month on unpaid accounts after 30 days.

Kindly give 24 hour notice of any appointment cancellation. Appointments not cancelled 24 hours prior, or missed appointments, are subject to a $30 No Show Fee that will be your responsibility, insurance carriers do not pay for missed appointments.

I, the undersigned certify that I (or my dependent) have insurance coverage as listed above and assign directly to Julie L.B. Door, LMP all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Julie L.B. Door, LMP to release all information necessary, including medical records, to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X_____ _____ _____

Signature **[ ] Patient [ ] Parent [ ]Guardian** Date Witnessed

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To Our Patients Regarding Cancellations and No-Shows

The following are our policies regarding cancellations and no-shows. We take this subject seriously because it **can make the difference between whether you succeed in your treatment or not.** Usually your referring doctor has prescribed a set frequency of treatment. Receiving these treatments at the prescribed frequency is vital to the rehabilitation of your injury and / or condition. If you receive treatments on schedule, the success and benefits will be greatly increased and recovery time will be quicker. Keeping your appointments is your most important responsibility during your rehabilitation. Other than that, all you need to do is follow your therapist's instructions and we will be able to help you achieve your goals in treatment.

• We require 24 hours notice in the event of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you receive the full prescribed number of treatments that week. (In some case, this may not be an option as treatment times are limited)

• There is a $30 charge for a cancellation without proper notice. This charge will not be covered by insurance and will have to be paid by you personally prior to receiving your next treatment.

• For Worker's Compensation and Personal Injury patients, documentation of missed appointments are part of your medical record and forwarded to the referring physician and/or case manager. This could jeopardize your claim and future referrals.

When you don't keep your appointment as scheduled, three people are hurt: you because you don't get the treatment you need as prescribed by the doctor and therapist; the therapist who now has an unusable space in their schedule since the time was reserved for you personally; and another patient who could have been scheduled for treatment if you had given proper notice.

Your cooperation in this regard is greatly appreciated. We're looking forward to working with you.

I have read and understand the above cancellation policy and agree to notify the massage therapist in advance of any cancellations I may need to make. I agree to pay said charge for any appointment not cancelled within 24 hours.

_____ _____

Patient Signature Date

_____ _____

Witnessed Date

Julie L.B. Door, LMP

Willows Chiropractic Clinic & Therapeutic Massage

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact **Julie Door** of our office at **(253) 841-6482, 2401 South Meridian Street; Puyallup, WA 98373.**

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other office personnel. The practices described in this notice will also be followed by health care providers you consult with by telephone (when your regular health care provider from our office is not available) who provide "call coverage" for your health care provider.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We must have your written, signed *Consent to* use and disclose health information for the following purposes:

For Treatment We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to Therapists, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example, your Therapist may be treating you for a spinal condition and may need to know if you have other health problems that could complicate your treatment. The Therapist may use your medical history to decide what treatment is best for you. The Therapist may also tell another Therapist about your condition so that Therapist can help determine the most appropriate care for you.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in referral requests, and scheduling diagnostic tests. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have.

For Payment We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Health Care Operations We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

Appointment Reminders We may contact you as a reminder that you have an appointment for treatment or medical care at the office.

Treatment Alternatives We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Products and Services We may tell you about health-related products or services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us in writing (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

You may revoke your *Consent* at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures which occurred before that time.

If you do revoke your *Consent*, we will not be permitted to use or disclose information for purposes of treatment, payment or health care operations, and we may therefore choose to discontinue providing you with health care treatment and services.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required By Law We will disclose health information about you when required to do so by federal, state or local law.

Research We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

Organ and Tissue Donation If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Military, Veterans, National Security and Intelligence If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners and Funeral Directors We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Information Not Personally Identifiable We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example medical supplies, or X-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization.* We must obtain your *Authorization* separate from any *Consent we* may have obtained from you. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization,* in writing, at any time. If you revoke your *Authorization,* we will no longer use or disclose information about you for the reasons covered by your written *Authorization,* but we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization (different than the *Authorization* and *Consent* mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment or health care operations, we will have to have both your signed *Consent* and a special written *Authorization* that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies as mandated by current RCW. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

To request an amendment, complete and submit a Medical Record Amendment/Correction Form to Julie Door. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.

b) Is not part of the health information that we keep.

c) You would not be permitted to inspect and copy.

d) Is accurate and complete.

Right to an Accounting of Disclosures You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to Julie Door. It must state a time period, which ***may not be longer than six years and may not include dates before April 14, 2003***. Your request should indicate in what form you want the list (for example, on paper, electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are Not Required to Agree to Your Request If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you may complete and submit *the Request For Restriction On Use/Disclosure Of Medical* Information to Julie Door.

Right to Request Confidential Communications You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit the *Request For Restriction On Use/Disclosure Of Medical Information And/Or Confidential Communication* to Julie Door. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact Julie Door.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Julie Door at (253) 841-6482, 2401 South Meridian Street, Puyallup, WA 98373. You will not be penalized for filing a complaint.