Anik J. St. Martin, DC, D.A.C.C.P.
Darin J. Shook, DC
Craig Werner, DC
John Dobosz, DC

Advantage
CHIROPRACTIC & MASSAGE

1312 Vandercook Way • Longview, WA 98632 • 360.425.6620 • Fax 360.425.1277
www.MyAdvantageChiro.com • contact@myadvantagechiro.com

Amy LaRiviere, LMP
Diane Miollis, LMP
Kim Clark, LMP
Matt Grimm, LMP

LABOR & INDUSTRIES / WORKER'S COMPENSATION

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Birth Date: _____ Age: ___ Sex: ☐ M ☐ F

Cell Phone: _____ Print Email: _____

Social Security # _____ Referral/How did you hear about _____

Check One: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Have you ever had a different name, maiden name? Please list: _____

Business Employer: _____ Type of Work: _____

Business Phone: _____ Business Address: _____

Name of Spouse: _____ Email: _____

Spouse's Employer: _____ Type of Work: _____

Business Phone: _____ Business Address: _____

Names and Ages of Children: _____

Person to Call if Unable to Reach You: _____

Phone # _____ Relationship: _____

Address: _____ City: _____State _____ Zip _____

Authorized Person to Discuss any Account/Health Information: _____

Phone # _____ Relationship: _____

Address: _____ City: _____State _____ Zip _____

CLAIM INFORMATION

Have You Filed a Report of Your Accident To Your Employer? ☐ Yes ☐ No Claim # _____

☐ Washington State L&I ☐ Self Insured Worker's Compensation Ins. Company _____

Claim Manager' Name _____Phone # _____

Washington State L&I does not cover more than one service per day. By signing below, I am aware of this and if I choose to schedule multiple services on the same day and payment is denied by my claim, I will pay the balance immediately.

These services would include, but are not limited to, exams, chiropractic adjustments, therapeutic exercises and massage.

Signature:_____Date:_____

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PERSONAL HEALTH INSURANCE

☐ I **do not** have personal health insurance. In the absence of insurance, any non-covered charges become patient responsibility.

Health Insurance Company _____

Billing Address _____

Phone _____ ID # _____ Group # _____

Policy Holder's Name: _____ DOB: _____

PAST HEALTH CONDITION

Previous illnesses you've had in your life:_____

_____

Have you ever broken any bones? Which?_____

Allergies: _____

Previous Injury or Trauma: _____

_____

_____

Surgeries: Date and type of surgery: _____

Females/ Pregnancies and outcomes: Are you currently pregnant? ☐ Yes ☐ No Due Date: _____

Pregnancies/Date of Delivery/Outcome/Miscarriages: _____

_____

Family Health History:

- Associated health problems of relatives:

_____

_____

Social and Occupational History:

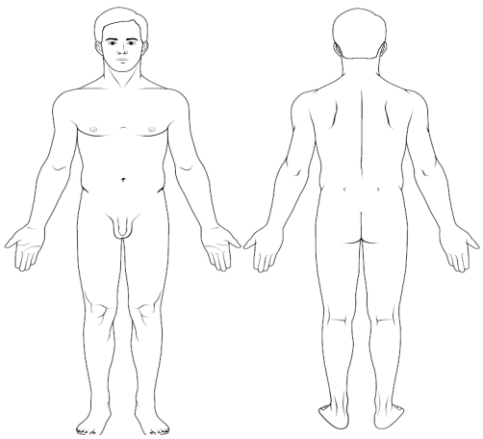
Job description:

_____

_____

Work schedule: _____

Please indicate areas of complaint in the diagram.



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Worker's Compensation Injury Worksheet

Date of Accident:_____Time:_____Location:_____

Please describe nature of accident/injury: ☐ Work related ☐ Work Related Auto Accident

If not auto collision, please describes the circumstances: _____

_____

If work related auto accident, were you ☐ Driver ☐ Passenger ☐ Pedestrian

Were you struck from ☐ Behind ☐ Front ☐ vehicle was parked ☐ R side ☐ L side

Did your Vehicle strike the others(s) involved? ☐ Yes ☐ No

As a result of the accident, was a traffic citation issued to you? ☐ Yes ☐ No

Were traffic citations issued to the driver of your car? ☐ Yes ☐ No

List the extent of the injuries as you know them_____

_____

Have you seen a doctor for this injury before coming to this office? ☐ Yes ☐ No

Did you receive treatment? ☐ Yes ☐ No If yes, describe_____

_____

SYMPTOMS Check (✓) symptoms you currently have or have had since the injury.

GENERAL
- ☐ Fatigue
- ☐ Tension
- ☐ Headache
- ☐ Loss of sleep
- ☐ Fever
- ☐ Irritability
- ☐ Sleeping problems

MUSCLE / JOINT / BONE
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Low back pain
- ☐ Shoulder pain
- ☐ Arm pain/numbness/weak
- ☐ Leg pain/numbness/weak
- ☐ Joint pain / Stiffness
- ☐ Walking problems
- ☐ Jaw pain

NERVOUS SYSTEM
- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress
- ☐ Loss of balance

CARDIO-VASC-RESP
- ☐ Chest pain
- ☐ Blood pressure problems
- ☐ Irregular heart beat
- ☐ Shortness of breath
- ☐ Stroke
- ☐ Blood clots
- ☐ Swelling of ankles

GASTROINTESTINAL
- ☐ Appetite poor / excessive
- ☐ Gas/Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Weight trouble
- ☐ Excessive thirst
- ☐ Indigestion / Heartburn
- ☐ Nausea
- ☐ Stomach pain
- ☐ Vomiting

EYE, EAR, NOSE, THROAT
- ☐ Vision problems
- ☐ Dental problems
- ☐ Hearing difficulty
- ☐ Difficulty swallowing
- ☐ Earache
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems

GENITO-URINARY
- ☐ Blood/discolor in urine
- ☐ Lack of bladder control
- ☐ Painful urination

SKIN
- ☐ Bruises
- ☐ Rash

Have you lost days of work? ☐ Yes ☐ No If yes, dates_____

Signature:_____Date:_____

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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 very 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 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 a 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 the 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 subluxations. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

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.

I have read and was supplied a copy of the **HIPPA guidelines.**

Signature:_____ Date:_____

OFFICE POLICIES

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

Please DO NOT wear strong perfumes or colognes. We see many patients with allergies and respiratory problems, strong scents can impair their progress.

Continued cancellations or missed appointments may result in being released from care.

Children are welcome here as patients and guests. If you bring children with you for your appointment, you are responsible for their actions at all times. Our staff will be happy to assist you with your well behaved children.

Please notify the Doctor of **any changes** in your health status, regardless of the significance.

Please silence cell phones or leave them in your car.

Signature:_____ Date:_____

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FINANCIAL POLICIES

Payment is expected at the time of service.

We accept the following forms of payment; Cash, Personal Checks, Debit Cards, Visa and MasterCard.

No balance policy: Any patient responsibility is expected at the time of service. Balances after insurance payments and any non-covered charges by insurance are due upon receipt of your statement.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Late Fee: A late fee of $10.00 will be imposed on each account that is over thirty (30) days past-due. All balances will accrue a $10 late charge every billing cycle.

Returned checks: There is a $25.00 fee for any checks returned by the bank.

Massage no show/late cancellation fee: If you do not show up for an appointment, or cancel with less than 24 hours' notice, a $10.00 fee will be charged. This late no show /cancellation fee goes directly to our massage therapists for compensation of time loss.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. All delinquent accounts bear interest at the legal rate. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Cowlitz County, Washington.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Insurance Billing: If we are contracted with your insurance company, we must follow our contract and their requirements. **Copays are due at the time of service.** It is the insurance company that makes the final determination of your eligibility.
We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility.
If you have any visit limit or dollar maximum it is your responsibility to keep track of this and be aware of your benefits.
Insurance coverage is never a guarantee of payment. If there are any problems between the insurance company and the patient, the patient would need to file a grievance directly with the insurance company. Your signature below indicates 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.
Your insurance company determines benefits when they receive our claims. Any statement made by our staff regarding your coverage is in no way a guarantee of payment for your services. I acknowledge that I am responsible for payment of all non-covered services.

Non-Contracted Insurance Billing: If you see a non-contracted (out of network) provider your insurance company may send you a check. You will need to sign the check and return it to our office for services rendered. I acknowledge that I am responsible for payment of all non-covered services.

Medicare: Medicare does not cover the following services at a Chiropractic office: Massage, Exams, Re-exams, X-Rays, Therapeutic exercises, Durable medical equipment or Supplements. We expect payment for any non-covered Medicare service at the time of your visit. If you have a copay with your supplemental insurance, it is to be paid at the time of your visit.

No Insurance Coverage: We do offer a time of service discount when services are paid in full at the time of the visit. By law, we must bill our full billable rate and cannot extend a discount if services are not paid for at the time of service.
We offer an additional 25% savings for all children and students as follows: newborn – age 18 and full time students to age 25.

Workers Compensation: We require approval/authorization by your employer and/or worker's compensation carrier. If your claim is denied, you will be responsible for payment in full.
In addition to this verification, we require that you allow us to bill your health insurance if your claim is denied. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney and/or insurance company. In addition to this verification, we require that you allow us to bill your health insurance if your claim is denied or you exceed your benefits. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility.

By signing below, I acknowledge that I understand the policies contained herein.

Print Patient's Name: _____

Print Responsible Party's Name (if not the patient): _____

Signature of Responsible Party: _____ Date _____/_____/_____