

Name: _____ Date: _____
(First/Middle/Last)
Birthdate: _____ Social Security #: _____ Sex: M ___ F ___
Address: _____ City/ZIP: _____
Home Phone: _____ Work: _____ Cell: _____
Employer: _____ Occupation: _____
Spouse: _____ Referred by: _____

Current Complaint: _____
When did it start? _____ Is it: Worse Better Same
Doctors seen for this condition: _____
Treatment Results: Good Fair Poor
Had this condition before? Yes No Are you pregnant? Yes No
Surgeries: _____
Falls/Broken bones: _____
Prior car accidents: _____
Medications: _____
Have you seen a Chiropractor before? (Give dates) _____
Have you ever had any of the following? (Check all that apply)

<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Bowel problems	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Prostate problems	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Urinary problems	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Nervousness
<input type="checkbox"/> Allergies	<input type="checkbox"/> Backaches	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Swollen Ankles	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Ulcers	<input type="checkbox"/> _____
<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Lung disease	<input type="checkbox"/> Headaches	<input type="checkbox"/> Migraines	<input type="checkbox"/> _____

Insurance Company: _____ ID#: _____
If not insured, person responsible for payment: _____

(Please give your insurance card and ID to the front desk assistant to be copied)

Emergency contact: _____ Phone: _____

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Ultimately it is my responsibility to be aware of my insurance benefits and coverage and that all charges incurred are ultimately my responsibility. I realize this office will prepare any necessary reports, forms and/or bills to assist me in making collections from the insurance company, and that any amount paid will be credited to my account upon receipt. If payment is sent to me by my insurance company, I agree to make an equal and prompt payment to Seattle Northeast Chiropractic. I also understand that this office reserves the right to attach interest in the amount of the 12% per annum (1% per month) to any account 60 days past due, and to charge me for appointments missed without 24 hours previous notice.

I authorize Seattle Northeast Chiropractic to request and receive any and all medical records, chart notes and x-rays, which may be deemed necessary, from previous physicians. I authorize this office to endorse checks made out to me from my insurance company for payment of my account only.

Signature: _____ Date: _____

Pain Drawing

Name: _____ Date: _____

Please be sure to fill this out accurately. Mark the area on your body where you feel the described sensation(s). Use the appropriate symbol(s) to mark areas of radiating pain and include all affected areas.

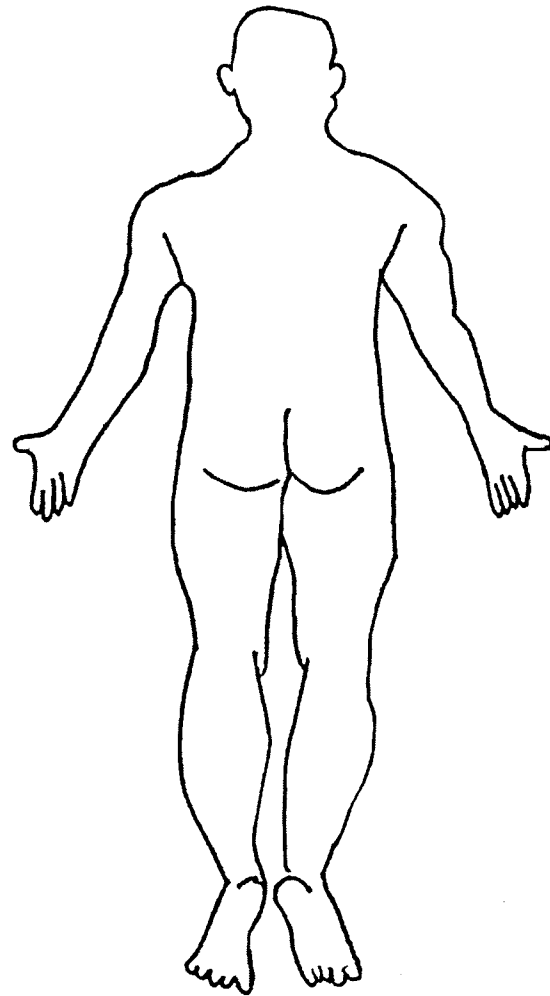
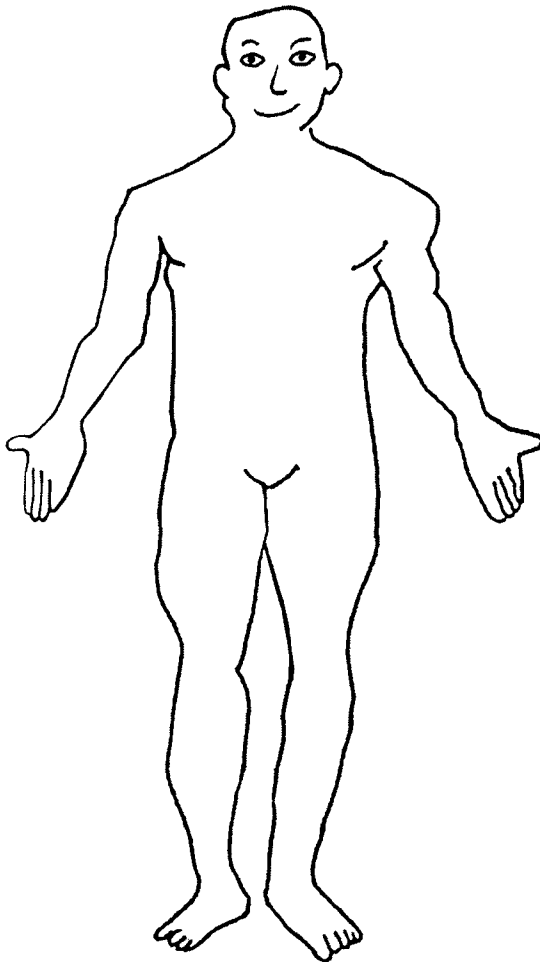
Numbness

Pins & Needles
OOOOOO

Burning Pain
XXXXXX

Stabbing Pain
/////

Aching Pain
((((



Visual Analogue Scale

Please mark on the line the pain level that most accurately represents your pain:

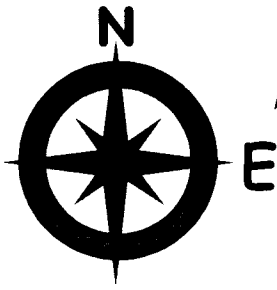
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (UNBEARABLE PAIN)

Right Now: _____

Average Pain: _____

At Best: _____

At Worst: _____



SEATTLE NORTHEAST CHIROPRACTIC
DR. LEO STUDZINSKI

**Authorization to Leave Health Information
By Alternate Means**

Patient Name: _____ Date of Birth: _____

Patient Mailing Address: _____

(Please check all that apply)

May leave detailed message on voicemail at home #: _____

May leave detailed message on voicemail at work # _____

May leave/discuss information with spouse (name): _____

May leave/discuss information with other family member: _____

May leave message on cellular phone #: _____

May leave detailed message on other phone # : _____

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change one or more of the telephone numbers listed above.

Patient or legally authorized individual signature

Date

11734 15th Ave NE ☞ Seattle, WA 98125
(206) 364-9501 phone ☞ (206) 440-8453 fax ☞ LeoGdc@aol.com

Billing Procedures and Payment Policy

Insurance coverage, Referrals and Pre-authorizations

We will gladly inquire about the extent of your insurance benefits for you. This does not guarantee payment by your insurance company. Some insurance plans require that you have a referral from your primary care physician (PCP) before they will cover a chiropractic visit. It is your responsibility to obtain any documentation you may need before your visits, so you don't receive an unexpected bill. Of course, we will fill out our portion of any pre-authorization forms required by your insurance company, but we cannot be responsible for the insurance company's decision to authorize care. Health insurance policies are an arrangement between the insurance carrier and you. Ultimately it is your responsibility to be aware of your insurance benefits and coverage. All charges incurred are ultimately your responsibility. This office will prepare any necessary reports, forms and/or bills to assist you in making collection from your insurance company.

Insurance co-payments

Insurance co-payments are a set amount that your insurance plan requires you pay up-front at each doctor's visit. We collect co-payments prior to your treatment at each visit.

Deductibles, Co-insurance payments and non-covered services:

After we bill your insurance company, we receive an Explanation of Benefits (EOB) along with any payment made. The EOB will itemize any amount you owe, and we will then send you a bill for that amount. We call these bills "spotbills" because we send them "on the spot" upon receiving the EOB from your insurance company. Because each insurance company's claim processing time is different, you may not receive a bill for 30 to even 90 days, and you may receive more than one bill per month. We do not send monthly itemized statements; you receive a bill from our office only when you have a balance due.

Medicare

Medicare will pay for chiropractic adjustments, and we are contracted with Medicare. Medicare does NOT cover exams or x-rays. Prior to receiving any service for which Medicare does not pay, we will tell you how much it costs so that you may make an informed decision about the services you want to receive.

Auto Accidents

Our office will inquire if your auto insurance coverage includes Personal Injury Protection (PIP). PIP is the preferred method of payment for auto accident injuries, as this means the doctor will receive timely payment for the care you receive, at no risk to your insurance coverage or premiums, regardless of who was at fault in the accident. If no PIP is available, it will be decided by the doctor if we can reasonably accept the case as a third-party claim. If our office is to attempt to collect payments from a third party insurance company, a personal lien will be filed with the King County Auditor's office. When the balance of the bill has been paid, the lien will be removed. Interest will be added to any balance 60 days past due at the rate of 1% per month (12% yearly). Our office will make a reasonable attempt to collect payment for you, but ultimately, any medical bills are your responsibility.

Work-related Injuries

Our office will assist you in filing a claim with Labor and Industries or your employer's self-insured company. It may take 4-6 weeks before the claim is either allowed or denied. There will be a period of time that you are incurring charges and do not yet know if your claim will be allowed. In the event that your claim is denied, your bill will be due and payable upon receipt. If your claim is denied and you have health insurance, we will attempt to submit a claim to them.

Supplies and Exercise Equipment

Dr. Studzinski may recommend supplies or exercise equipment that may help you with your recovery. These are usually not covered by insurance. If you choose to purchase supplies or equipment at this office, payment is due upon receipt of the product. If your insurance company pays for your products, your payment will be refunded.

Rescheduling Appointments

Dr. Studzinski recommends a specific treatment plan for your condition, and a timely recovery will depend on keeping to that treatment plan as closely as possible. If you must reschedule an appointment, we ask for 24 hours notice.

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Leo G. Studzinski, DC respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Your Health Information Rights

The health and billing records we create and store are the property of the practice. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice;
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request. But we will comply with any request granted;
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information (“Notice”);
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.
- Have us review a denial of access to your health information—except in certain circumstances;
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your health record, and included with any release of your records.
- When you request, we will give you a list of disclosures of your health information. The list will not include disclosures to third party payors. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

Our Responsibilities

We are required to:

- Keep your protected health information private;
- Give you this Notice;
- Follow the terms of this Notice.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our office to pick one up.

To Ask for Help or Complain

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may *contact*:

Trina Burget
11734 15th Ave NE
Seattle, WA 98125

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to Trina Burget at our practice/health care facility. You may also file a complaint with the U.S. Secretary of Health and Human Services.

We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

Disclosures and Uses of Protected Health Information

Seattle Northeast Chiropractic
11734 15th Ave NE
Seattle, WA 98125

Notification of Family and Others

- Unless you object, we may release health information about you to a friend or family member who is involved in your health care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital. In addition, we may disclose health information about you to assist in disaster relief efforts.

Other Uses and Disclosures of Protected Health Information

- Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.

Effective Date: April 14, 2003

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 Trina Burget at (206) 364-9501.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information. This form will be retained in your health record.

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

Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Leo G. Studzinski, DC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Leo G. Studzinski.

Signature of patient or authorized representative

Date

Printed name if signed on behalf of patient / Relationship (parent, legal guardian, personal representative, etc.)
(Notation, if any, by staff)