Date:__________ Patient Name: ______________________________ Patient ID:__________

WARWICK CHIROPRACTIC AND MASSAGE

8650 Martin Way E #207, Lacey WA 98516

CONSENT TO TREATMENT, BILLING INFORMATION, and PRIVACY PRACTICES

Billing Policy

Our office will provide insurance billing services for you as a courtesy. Your health insurance benefits are based on a contract between you and your health insurance carrier and **any benefits quoted are not a guarantee of payment**.

I authorize direct payment of medical benefits, from my insurance company to Warwick Chiropractic & Massage, PLLC, any and all healthcare provider employees of Warwick Chiropractic & Massage, PLLC, and / or supplier for any services performed at this office. I also authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to the party that accepts assignment. I agree that Warwick Chiropractic & Massage may contact me via HIPAA compliant email and/or text messaging regarding billing matters.

It is understood that all reasonable efforts will be made to collect from my insurance company, and final determination of payment will only be made after claims have been received and processed.

I understand that any and all amounts which are not collected from my insurance company shall become my responsibility, and I agree to pay those charges within 30 days. I further agree that any insurance reimbursement check that I receive directly from the insurance company (usually if our office is out of network), shall be transferred to Warwick Chiropractic & Massage, PLLC in full within 10 days of my receipt of the check. If I owe a deductible, coinsurance, or co-pay for my treatment, I agree that I shall pay at time of service. I understand that it is my responsibility to pay any deductible amount, copays, coinsurance, and / or any other balances that are not covered by my contract or paid by my insurance carrier.

I understand that motor vehicle accidents and workers' compensation cases with outstanding balances, as well as all other past due accounts that are sent to collections 120 days or more after the first statement I receive, will be charged 9% interest fee annually. I authorize direct payment from my attorney to pay for all outstanding bills for my motor vehicle accident and / or workers' compensation case.

Fee Schedule:				
	New Patient Exam	$47-350	Existing Patient Exam	$35-325
	Spinal Adjustment	$52-105	Extremity Adjustment	$55
	Mechanical Traction	$50	Therapeutic Exercises	$50
	Myofascial Release	$50	Therapeutic Activities	$65
	After Hours	$50	Sunday/Holiday	$50
	Reports	$45-75	Hot/Cold Packs	$25
	Teleconference	$65-285	X-Ray / CT / MRI Review	$50-75
	CRMA Analysis	$500-1000	Durable Medical Equipment	$225-1450
	Massage Therapy	$95-200		

If I am not covered by any type of insurance, I understand that I am responsible for my bill in full. My bill may be additional services in addition to a chiropractic adjustment, including but not limited to: initial examination, progress / update exam, cold laser therapy, and/or any other services provided by doctors in our office that are in addition to a chiropractic adjustment.

I, (print name) ______________________________, understand and agree to Warwick Chiropractic & Massage, PLLC's billing policy.

Signature______________________________ Date__________________

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Chiropractic Examination

In order to provide an appropriate evaluation and treatment recommendations, a doctor will need to obtain a medical history from you and perform an examination. This examination will include palpation, where the doctor uses his hands on your spine, and/or other joints, and the surrounding soft tissue. Palpation allows the doctor to assess joint function and areas of subluxation. Your examination may also include other evaluations techniques such as: assessing your range of motion,

orthopedic and neurological testing, imaging studies (like x-rays), obtaining your blood pressure and other relevant vital signs. Some portions of the examination may elicit or aggravate your pain or symptoms. It is important that you communicate all symptoms to the doctor and advise him/her if any portion of the examination causes you pain. All our patients are encouraged to ask questions before, during and after all aspects of the examination and subsequent care.

I, (print name) ____, understand and agree to Warwick Chiropractic & Massage, PLLC's Chiropractic Examination.

Signature____ Date__________________________

HIPAA – Privacy Practices

I acknowledge that I have received the practice's Notice of Privacy Practices for protected health information. Which includes, but is not limited to: locking all computers before leaving the room, logging off each profile at front desk and on doctors' computers, and each computer has a password that only staff members know. Server information is on multiple backups that no one outside of the office has access to and is protected via passwords for patient security. Our software system is password protected, each employee has their own login information and password. We also have an IT support team on monthly retainer to maintain our HIPAA compliance. If you have any additional questions on how YOUR information is protected please ask the Front desk staff.

I, (print name) ____, have been provided and understand Warwick Chiropractic & Massage, PLLC's Privacy Practices.

Signature____ Date__________________________

Chiropractic Treatment

Procedure: Chiropractic adjustment or manipulation is a manual procedure where the doctor uses his/her hands – or an instrument – to manipulate the joints of the body to restore or enhance joint function and mobility. You may hear an audible "pop" or "click" or feel or sense movement. Chiropractic care may include any of the following depending on your condition: chiropractic adjustments of the spine or other joints, manual muscle work such as massage, traction, heat or cold therapy, the use of therapeutic exercise, cold laser light therapy and the use of nutritional counseling and supplementation. Your doctor will discuss with you a proposed treatment plan, which may at times be carried out by other doctors in the clinic or trained staff.

Risks: Chiropractic care, as in the practice of medicine and all healthcare, carries some risk during examination and treatment. Patients may experience temporary muscle soreness, inflammation, dizziness, worsening of symptoms with treatment, therapies or physical examination. Soreness following treatment, like that following exercise, should resolve within 24-48 hours. While the chances of experiencing serious complications are rare, it is the practice of this clinic to inform our patients about them. These complications include, but are not limited to, burns or skin irritation from heat or other therapies, sprains/strains, disc injuries, dislocations or rib fractures following any manual technique. More serious complications are extremely rare. Vertebral artery dissection is *associated* with many neck movements, including chiropractic adjustments of the cervical spine. Current research indicates vertebral artery dissection is not caused by, but is *associated* with, cervical adjustment. According to some authorities,

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the association between cervical adjustments and vertebral artery dissection is one in a million (1 in 1 million). Vertebral artery dissections can lead to medical complications, including stroke. Additional information on side-effects, risks and complications is available upon request. If you have any unusual symptoms following treatment, you should immediately advise your doctor and seek care.

Patient Participation: In order to provide you with the best recommendations and evaluate contraindications to care, it is critical you provide us with complete and accurate information about your medical history, symptoms, medications and changes in condition or symptoms. In some instances, it is important we coordinate your care with your other providers, and/or refer you to other specialists.

Alternatives: In addition to the alternative therapies offered by this clinic, other treatment options for musculoskeletal conditions may include rest, over-the-counter analgesics, prescription medications, injection therapies, acupuncture, physical therapy and surgery. Each of these actions carry their own sets of risks, some significant, and should be discussed in detail with your other healthcare providers. Remaining untreated may result in the formation of adhesions and reduced mobility, which can complicate future treatment and rehabilitation.

I hereby acknowledge that I have provided complete and accurate information regarding my health history, medication and symptoms and will notify my doctor if there are any changes to same. I have discussed with the Doctor of Chiropractic the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I understand there is no guarantee or warranty for a specific cure or result. I hereby give my full consent to treatment.

A patient, in coming to the Doctor of Chiropractic, gives the doctor permission and authority to care for the patient in accordance with the tests, diagnosis, and analysis. The chiropractic adjustments, spinal decompression, massage therapy, or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if they are aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures, whatever s/he is suffering from: latent pathological defects, illnesses or deformities, which would otherwise not come to the attention of the Doctor of Chiropractic. The Doctor of Chiropractic provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I understand that if I am accepted as a chiropractic patient at Warwick Chiropractic and Massage, PLLC, I am authorizing any licensed healthcare provider employees of Warwick Chiropractic and Massage, PLLC, to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic, spinal decompression, or massage treatment, will be explained to me upon my request. I agree with the current or future recommendation to receive chiropractic, massage, and/or spinal decompression care as is deemed appropriate for my circumstance. By signing below, I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) from which I seek care from this office.

Full name________________________________ Date______________

Signature____