Lynnwood Family Massage Policy

Welcome to Lynnwood Family Massage! The following is an explanation of our office policies and procedures. We believe that a clear understanding will allow us both to concentrate on the most important issue: regaining and maintaining your health. We are happy to answer any questions that you may have and are grateful to be at your service.

I understand that it is my choice to receive massage therapy and that massage therapists do not diagnose or prescribe. I agree to communicate with my practitioner regarding any changes in my insurance plan or financial circumstances. I further agree to communicate with my practitioner any time I feel my well-being is being compromised.

I understand that massage therapy is used to reduce stress, muscular tension, and pain. I understand there are no guarantees for recovery and if I am unsatisfied with the progress made with my treatment I will inform the therapist, so he/she may direct me to another treatment. However, I am financially responsible for the services rendered.

The procedure time for your treatment is 45-60 minutes. When you schedule, one full hour is set aside specifically to meet your needs. We do not double-book appointments and are unable to place another client in your space without sufficient prior notice. Therefore, it is imperative that you arrive 15 minutes prior to your appointment.

CANCELLATION POLICY

Our time is valuable, too. Cancellation notice is required **24** hours prior to your treatment time. **24** hours allows us to make your time slot available to another client in need of treatment. If sufficient notice is not given, and we are unable to fill your time slot, there will be a $40.00 charge to the credit card you enter below.

**** We are unable to bill your insurance for cancellation fees. It is solely your responsibility. ****

Card number:_____

Exp. Month/Year:_____/_____

Full name on card:_____

MY SIGNATURE INDICATES THAT I HAVE READ, UNDERSTAND AND AGREE TO THE POLICIES STATED ABOVE.

CLIENT SIGNATURE: _____

PRINTED NAME: _____DATE:_____

Lynnwood Family Massage Confidential Information

NAME: _____ BIRTHDATE____/____/____

Please answer the following questions by circling YES or NO and provide any necessary clarifications.

YES NO Have you ever had a professional massage?

YES NO Do you exercise regularly or participate in any sports? What kind and how often?

_____

YES NO Are you currently under the care of any other health care provider for a specific condition?

YES NO Do you take any vitamins, minerals, or medication (including aspirin or ibuprofen)
Please list medication, dosage, and condition _____

_____

YES NO Have you ever had surgery? Please list date(s) and procedure(s) _____

_____

YES NO Do you have or have you ever had cancer? What type and when? _____

_____

YES NO Do you have or have you ever had heart problems? Please explain: _____

_____

YES NO Do you have high or low blood pressure? Please circle one.

YES NO Do you have varicose veins, blood clots or any other circulatory conditions not mentioned? Please explain: _____

YES NO Do you have diabetes? How is it controlled? _____

YES NO Do you have arthritis? Osteoarthritis or Rheumatoid? (please circle one)
Where is it located? _____

YES NO Do you have bone or joint problems? Please describe: _____

YES NO Do you experience prolonged episodes of depression or other emotions?

YES NO Do you have any infections or contagious diseases? Please explain: _____

_____

YES NO Are you experiencing any sleep disorders or changes in normal sleeping patterns?
Please explain: _____

YES NO Are you pregnant? What stage? _____

YES NO Do you wear contacts, dentures, or hearing aids? _____

YES NO Do you have any other medical conditions your therapist should be aware of before you receive massage?_____

YES NO Do you have any needs that require special attention? Please explain: _____

_____

Please read carefully, sign, and date.

I understand that massage therapists do not diagnosis illness, disease or any other physical or mental disorders. Massage therapists do not prescribe medical treatment or pharmaceuticals. It has been made clear to me that massage is not a substitute for medical examination or diagnosis and that is recommended that I see a physician for any ailment I may have. I have stated all my known medical conditions and I am responsible to inform my massage therapist of any changes in my physical or mental health. I understand that my massage therapist is an independent contractor at Lynnwood Family Massage. I indemnify and hold harmless Lynnwood Family Massage from any loss or liability arising from services provided by my massage therapist.

SIGNATURE_____ DATE_____/_____/_____

Lynnwood Family Massage Patient Registration

LAST NAME: _____FIRST NAME: _____M.I.____

BIRTHDATE: ____/____/_____

ADDRESS _____

CITY: _____STATE: _____ZIP CODE: _____

CELL#____-____-_____HOME#____-____-_____WORK#____-____-_____

EMAIL: _____

PLEASE CIRCLE ONE: SINGLE - MARRIED - DIVORCED - WIDOWED – OTHER

EMPLOYED? FULL TIME / PART TIME STUDENT? PART TIME / FULL TIME

SCHOOL / EMPLOYER: _____

EMERGENCY CONTACT: _____# ____- ____-_____

HOW WERE YOU REFERRED TO LFC? _____

WOULD YOU LIKE US TO VERIFY YOUR MASSAGE THERAPY BENEFITS?

PRIMARY INSURANCE: _____

SUBSCRIBER NAME: _____BIRTHDATE ___/____/____

SUBSCRIBER EMPLOYER: _____

INSURANCE ID # (PLEASE INCLUDE LETTER PREFIX) _____

RELATIONSHIP TO SUBSCRIBER: (PLEASE CIRCLE) SELF, SPOUSE, CHILD, OTHER

*SECONDARY INSURANCE: _____

SUBSCRIBER NAME: _____BIRTHDATE ___/____/____

SUBSCRIBER EMPLOYER: _____

INSURANCE ID # (PLEASE INCLUDE LETTER PREFIX) _____

RELATIONSHIP TO SUBSCRIBER: (PLEASE CIRCLE) SELF, SPOUSE, CHILD, OTHER

**** Benefits quoted are not a guarantee of payment and any balances not covered by the insurance carrier are the sole responsibility of the patient. ****

LYNNWOOD FAMILY CHIROPRACTIC
John J. Sim, DC
16303 Hwy 99, Suite 1B
Lynnwood, WA 98087
(425) 743-9460

Financial Policy and Agreement

I agree that in return for the services provided by the doctor at Lynnwood Family Chiropractic, I will pay my account at the time services are rendered or I will make financial arrangements satisfactory to Lynnwood Family Chiropractic for payment. If my insurance company or health plan designates co-payments, co-insurance and/or deductibles, I agree to pay them to Lynnwood Family Chiropractic. All service balances are due and payable at the time of service. If payment is not received, we reserve the right to refuse future appointments on delinquent accounts.

No Insurance Coverage: Payment is expected on the day that services are rendered. A twenty percent fee reduction will be applied to services only if paid in **full** at the time of service. We accept cash, check, or credit card.

Insurance: Insurance is a contract between you and your insurance company. You will need to pay your co-insurance and/or co-payments at the time of service. If you choose to pay for all of your treatment in full at time of service we will promptly issue a refund or credit your account for future care for any credit balance. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the **final determination** of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by them. **If your insurance company requires a referral and/or pre-authorization, it is your responsibility to obtain and provide it to our office.** Failure to obtain the referral and/or pre-authorization may result in a denial from the insurance company, and the balance will be your responsibility.

Medicare: We are a participating provider with Medicare Part B. We agree to bill and accept contractual adjustments from Medicare. There may be services and supplies rendered in our office that are not covered by Medicare and therefore require an Advanced Beneficiary Notice (ABN) be signed by the patient/Guarantor. By signing the ABN, it is understood that you are financially responsible for payment of any services and/or supplies that are not deemed medically necessary by Medicare.

Monthly Statement: If there is a personal patient balance on the account, we will send you a monthly statement. Patients are responsible for all charges resulting from treatments provided at Lynnwood Family Chiropractic. Payment is due within 30 days of receipt of this statement, unless other financial arrangements have been made.

Past Due Accounts: I understand and agree that if my account is delinquent past 90 days without financial arrangement with the office, I may be turned over to the collection agency used by Lynnwood Family Chiropractic.

Returned Checks: There is a fee of $35.00 for any checks returned by the bank for any reason.

Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

_____ _____

Patient/Legal Guardian Signature Date

_____

Print Patient Name

LYNNWOOD FAMILY CHIROPRACTIC
John J. Sim, DC
16303 Hwy 99, Suite 1B
Lynnwood, WA 98087
(425) 743- 9460

PATIENT PRIVACY NOTICE
DATE: 1/1/2009

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with the notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

We are required by law to have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payments for or reimbursement of the care we provide to you, and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information for medical information for other purposes without your consent or authorization.

As our patient, you have important rights relating to the inspecting and copying your medical information that we maintain, amending or correcting that information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

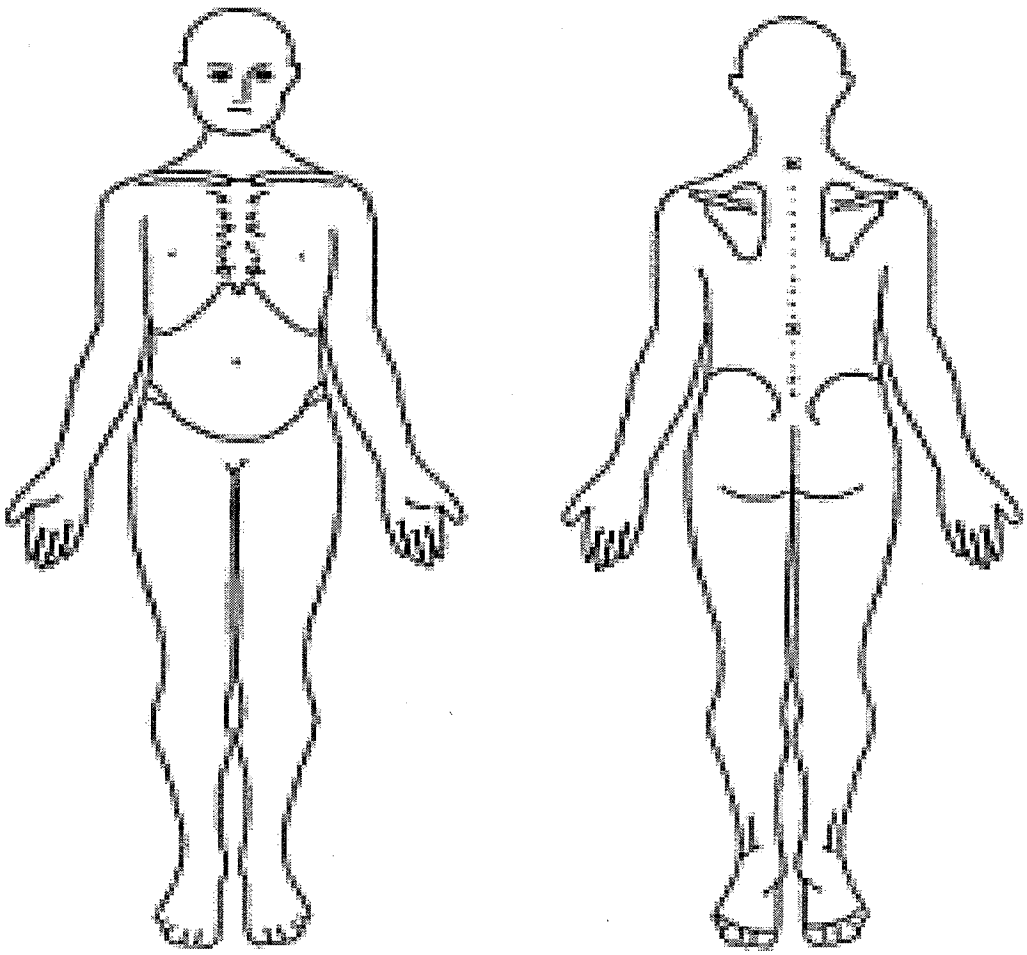
We have available a detailed NOTICE OF PRIVACY PRACTICES which full explains your rights and our obligations under the law. We may revise our NOTICE form time to time. The effective date at the top right hand side of this page indicates the most current NOTICE in effect.

You have the right to receive a copy of our most current NOTICE in effect. If you have not yet received a copy of our current NOTICE, please ask at the front desk and we will provide you with a copy.

* By signing below you agree that you have read and understand the above NOTICE. You also understand that this is a condensed version of our privacy practices and at any time you may request a copy of the entire notice of privacy practices, or it is available for review at our front desk counter.

Patient/Guardian Signature Date

Lynnwood Family Massage



Circle which part(s) of your body that is bothering you then mark that part of the body on a scale from 1-10 with 10 being the worst pain ever.