1750 112th Ave NE Suite C-240
Bellevue, WA 98004
Phone: (425) 688-1994
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www.eastsidefamilychiropractic.com

Eastside Family Chiropractic
& Wellness

Dr. Jerry Wang, D.C., P.S., Inc.

Patient Confidential Information

Date:________________________

Name:____ Nickname:________________________
First M.I. Last

Address:____ ________________________ __________ ____________
Street City State Zip Code

SSN: ________-_____-________ Gender: ☐Male ☐Female Date of Birth: ______/______/_______ Age:_______
Month Day Year

Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Legally Separated ☐Domestic Partner

Occupation:______________________________ Employer:____

Cell Phone:(_____)_________________________ Home Phone:(_____)__________________ (Write “none” for no landline)

Work Phone:(_____)__________________Ext:________

Primary phone number to reach you by: ☐Cell ☐Home ☐Work ☐ Other ______________________

E-mail to reach you by:____

Primary contact preference: ☐Cell ☐E-mail ☐Work ☐No preference

Emergency Contact:________________________________ Phone Number:(_____)___________________

Relationship to you:________________________________

How did you hear about us? ☐Website ☐Insurance ☐Friend/Family________________________ ☐Other _____________

Primary Insurance Information

Insurance Company:_______________________________________ ☐Health Insurance ☐ Auto Insurance

Health Insurance ID#:____________________________ Group#:______________________

Auto Insurance Claim#:____________________________ Auto Insurance Phone#:______________________

Insurance Subscriber:____________________________________ Subscriber Relationship to you:______________________

Subscriber SSN:________-_____-________ Gender: ☐Male ☐Female Subscriber Date of Birth:______/______/_______
Month Day Year

Past/Current Medical History

☐Heart Attack/Stroke
☐Cancer/Tumor
☐Allergies/Sinus Problems
☐Asthma/Emphysema
☐Digestive Disorders
☐Alcohol/Drug Abuse
☐Low Back Problems
☐Skin Rash
☐Heart Surgery/Pacemaker
☐Diabetes/Tuberculosis
☐Pulmonary Diseases
☐Ulcer / Colitis
☐Venereal Diseases
☐Joint Arthritis
☐Psychiatric Disorders
☐Wear Contacts
☐Heart Disease/Murmur
☐High/Low Blood Pressure
☐Fainting/Seizures/Epilepsy
☐Multiple Sclerosis
☐HIV+/AIDS
☐Neck Problems
☐Liver/Kidney Diseases
☐Wear Dentures

◆List any other serious medical condition(s) you have or ever had:__________________________________
◆Do you have any metal or electrical implants? ☐Yes ☐No ◆Are you taking any medication? ☐No ☐Yes List:_____________________
◆Have you been treated by physician in the past year? ☐No ☐Yes Describe the condition:____________________________________
FOR WOMEN: Are you taking Birth Control? ☐No ☐Yes Are you Pregnant? ☐No ☐Yes # months:_____

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

EASTSIDE FAMILY CHIROPRACTIC & WELLNESS
DR. JERRY WANG, D.C., P.S., INC.

1750 112TH AVE. NE SUITE C-240
BELLEVUE, WA 98004

In consideration of your undertaking to treat me, I agree to the following:

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred for services rendered to me by you or any member of your staff acting on your behalf.

I authorize the direct payment to you of any sum I now or hereafter owe you upon settlement of my case (Personal Injury patient only).

In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. After all reasonable efforts have been made to collect the sums due from my insurance company or settlement of my case; I understand that I am personally responsible for any unpaid balance on my account.

BILLING & PAYMENT

All patient responsibilities are due at the time of service (Co-pay, Co-Insurance, Deductible and Non Covered Services). In an event patient responsibility is unable to be determined at the time of service. Patient agrees to the 15 day billing cycle with due dates on the 15th or 30th of each month. I understand that any patient responsibility past 30 days is subject to $8.00 late fee. Any returned checks are subject to a $25.00 fee. I am responsible for my patient responsibility and fees, and I understand that any remaining balance after 90 days from the initial billing date may be transferred to a collection agency.

DISCLOSURE FOR AUTO INJURY CASE

I am receiving care for my auto injury from Eastside Family Chiropractic. I authorize the charges to be sent to my Auto PIP insurance. I understand that Eastside Family Chiropractic will not bill my health insurance for my auto injury claims, and I am fully responsible for my bills. I will provide the staff with my current attorney and/or auto insurance information along with any changes.

TERMS OF ACCEPTANCE

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 towards the same objective. Chiropractic has only one goal. It is 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.

Adjustment: An adjustment is the specific application of force to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.
Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.
Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function an interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than the vertebral subluxation complex. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

Massage Care

We provide massage therapy for the basic purpose of relaxation and relief of muscular tension. If you experience any discomfort during the session, immediately inform the therapist so that the pressure and stroke may be adjusted for the treatment. Massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness. You are responsible for informing the therapist with all known medical conditions as well updating the therapist with any changes in which if you fail to do so, there shall be no liability on the therapist's part.

The licensed therapist reserves the right to refuse massage therapy on anyone whom he/she deems to have a condition for which massage is contraindicated.

Massage Cancellation Policy: A minimum of 24 hour notice must be given for any massage appointment cancellation. Failure to do so or no shows will be subject to a $30.00 fee. If the office is closed, please leave a message with your name and appointment date and time to cancel your appointment. You can also e-mail info@eastsidefamilychiropractic.com to cancel your appointment.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to diagnostic and treatment options that Eastside Family Chiropractic and Wellness deems appropriate for my care.

All questions regarding the doctor and therapist's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept Chiropractic, Massage Therapy care on this basis, and I agree to the authorization and assignment of benefits and billing and payment policy.

____
Print Name

____________________________________ ______________
Signature Date

For Minor's Consent:

I hereby authorize Eastside Family Chiropractic and Wellness and whomever he/she may designate as his/her assistants to administer treatment as he/she so deems necessary to the patient above.

____
Print Parent/Guardian Name

____________________________________ ______________
Signature of Parent/Guardian Date

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Eastside Family Chiropractic & Wellness

Privacy Officers: Dr. Jerry Wang, D.C.,P.S., Inc.
Effective Date: April 14th 2003
1750 112th Ave. NE, Suite C-240, Bellevue, WA 98004 (425) 688-1994

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.
We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notices of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have you any questions about this Notice, please contact the Privacy Officer at this practice.

Who Will Follow This Notice Any health care professional authorized to enter information into your medial record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be will be shared.

How We May Use and Disclose Medical Information About You The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

For Treatment. We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations. We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made Without Consent or Authorization
- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers' treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situation
- Health oversight activities
- Other public health activities

We may contact you to provide appointment reminders or information about treatment alternative or other health-related benefits and services that may be of interest to you.

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided you.

Your individual Rights Regarding Your Medical Information Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations or to someone who is involved in your care or the payment for you care. 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 with emergency treatment. To request restriction, you must submit your requesting writing to the Privacy Office at this practice. In your request, you must tell us what information you want to limit.

Right to Request Confidential Communications. You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. 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. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decision about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you maybe ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. 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 the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Right to an Accounting of Non-Standard Disclosures. You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: on paper or electronically). The first list you request within a 12-month periods will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice.

Changes To This Notice We reserve the right to change this Notice. We reserve the right 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 copy of the current Notice, with the effective date on the upper right corner of the first page. I have read and understand this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make change regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Patient Name:______________________________

Date of Birth:_______/________/_______

Signature:__________________________________

Date:_______/________/_______