



Dr. Darryl Roundy & Associates

Name: _____ Date of Birth _____ Age _____

Address: _____ City _____ State/Zip _____

Phone: (Home) _____ (Work) _____ E-mail: _____

Occupation: _____

Areas of stress, pain, or tension: _____

Who referred you?: _____

Please take a moment to carefully read the following questions. If you have a specific medical condition or specific symptoms, massage may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Yes No Have you ever experienced a professional massage?

If you answer "yes" to any of the following questions, please explain as clearly as possible.

- Yes No Do you frequently feel stressed? Yes No Do you have diabetes?
 Yes No Do you experience frequent headaches? Yes No Are you pregnant?
 Yes No Do you suffer from arthritis? Yes No Are you wearing dentures?
 Yes No Do you suffer from joint swelling? Yes No Contact lenses?
 Yes No Do you have any contagious disease? Yes No Do you have varicose veins?
 Yes No Do you suffer from epilepsy or seizures? Yes No Do you have osteoporosis?
 Yes No Have you had any broken bones in the past two years? Yes No Do you bruise easily?
 Yes No Do you have high blood pressure? Yes No Do you have any allergies?
 Yes No Do you have spinal problems? Yes No Do you have cancer?
 Yes No Have you been in an accident or suffered any injuries in the past two years?

Please list all medications: _____

Please list other medical conditions: _____

Check the areas of your body that you give permission to receive massage:
 back legs buttocks arms abdomen chest neck head face feet hands

Therapeutic breast massage will not be performed. Draping will be used during the session. Clients under the age of 18 must have written consent from a parent/guardian.

The techniques used during the session will consist of Swedish, Deep Tissue, Trigger Point Therapy, Myofascial Release and Manual Ligament Release.

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all of my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Signature of Client _____

Date _____



Dr. Darryl Roundy & Associates

FINANCIAL POLICY

Payment is expected at the time services are rendered. We accept cash, check, debit card, Visa/ MasterCard and Discover.

Insurance: If your insurance offers chiropractic coverage, we will be happy to bill your insurance directly. If we are contracted with your insurance company then we are obligated by our contract to only submit claims to them. **If we have not been successful in collecting from your insurance company after 120 days we will then bill you for the amount pending and it is your responsibility to collect from your insurance company.** You will be responsible for any amount that your insurance plan does not cover. If you have filed a claim under your personal injury protection (PIP), **you** are responsible for any outstanding balances on your account. Co-payments and/or coinsurance balances are due at the time of service unless we are contracted with your insurance company and it is otherwise stated. Insurance coverage is a contract between you and your insurance company; we file insurance claims as a courtesy to our patients. **Medicare patients** - please discuss your coverage and our policy with our office staff prior to being seen by the doctor.

Non-covered services: If insured, your insurance covers chiropractic care that is curative, reasonable and necessary. By definition, they can interpret that some ongoing care is not under that category and may be denied, either during the course of care, or upon paper review or audit. **They may consider it to be maintenance, preventive, or purely wellness care, which is not a covered service.** If insurance denies payment or seeks reimbursement from us for ongoing visits deemed to be a non-covered service by the reasons listed above, the patient is responsible for payment of services. The patient accepts the responsibility to pay for treatment that is deemed a non-covered service by their insurance.

Account balances: Interest at the rate of 1% per month will be added to all balances over 30 days. If you have been in a motor vehicle accident and have a claim pending and/or an attorney and you have a balance that is accruing interest, you are responsible for that interest each month, you will be billed. If we are not receiving payment from an insurance company on a regular basis you will be expected to make a monthly payment toward that account that can be reimbursed to you at time of settlement. A lien will be filed on all accounts that have an outstanding balance pending settlement. Agency fees will be added to all accounts that are turned over for collections. There will be a \$30 service charge for returned or N.S.F. checks.

Appointments: If you are unable to make a scheduled chiropractic appointment, a phone call to reschedule or cancel your appointment is required. If you do not show up for an appointment and do not call to cancel your appointment, it will be to the doctor's discretion as to whether or not he/she will continue to treat you. If you are late for your scheduled visit, we will do our best to fit you in as soon as possible.

For massage therapy, we require 24-hour notice for any cancellation or appointment needing to be rescheduled. Last minute cancellations or no-shows will result in a \$50.00 non-refundable fee that will not be billed to insurance and will need to be paid in full prior to any treatment received at our office. If you show up to your appointment late, you will be responsible for the full amount of the massage time scheduled (i.e. if you show up 20-minutes late for a 1-hour massage, you are responsible for the full 1-hour charge even though the full hour can not be performed); if you are using insurance for massage benefits, we can only bill your insurance for the amount of time massage is performed; the amount of time you were late will have to be paid at the time of service and can not be billed to your insurance.

Record Copies: You have the right to review your personal health care records. Fees for copying your personal health information/records are set by state regulators annually (WAC 246-08-400). The fees are a \$23 clerical fee plus \$1.02 per page for the 1st 30 pages and \$0.78 per page thereafter plus tax.

I, _____ have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Signature: _____

Date: _____



Dr. Darryl Roundy & Associates
Authorizations and Releases

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available here:

<http://www.cms.hhs.gov/SecurityStandard/Downloads/securityproposedrule.pdf>

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
5. Patients have the right to file a formal complaint with our privacy official about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Initial _____

Consent to Professional Treatment

The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. The patient may refuse treatment at any time.

Initial _____

Consent to Perform and Interpret X-rays

The patient consents to the performance of x-rays as deemed necessary by the attending physician of this office. The patient acknowledges that certain risks are associated with x-rays. The patient, hereby states that they have no known limitations that would forbid the taking of x-rays. The patient further agrees that this office may seek outside interpretation of patient x-rays by a qualified professional not employed by this office. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third-party payor.

Initial _____

Assignment of Benefits and Release of Records

The patient hereby assigns benefits to be paid directly to this provider by all of their third party payors. This assignment is irrevocable. Failure to fulfill this obligation will be considered a breach of contract between the patient and this office. The patient authorizes this office to release any information required by a third party payor necessary for reimbursement of charges incurred.

Initial _____

Financial Obligation and Appointment Policy

The patient accepts full financial responsibility for services rendered by this practice. This office reserves the right to charge fair market value for missed appointments or appointments cancelled without any advanced notification required by this office. Payment in full is required for all services at the time of visit, unless alternative arrangements have been agreed to in advance. Patient accepts full responsibility for any fees incurred, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. Patient should direct any questions regarding this financial obligation and appointment policy to the clinic manager or physician. The patient further authorizes the practice to retain credit card, debit card, checking account or other payment source(s) supplied by patient to the practice for current and future charges, when incurred.

Initial _____

Signature _____ Date _____

Specializing in Atlas Orthogonal, Chiropractic Pediatrics and Extremity Care

2310 Mildred St. W., Suite 130 // University Place, WA 98466 // p: (253) 460-4244 // f: (877) 841-5137



Dr. Darryl Roundy & Associates

Consent for Purposes of Treatment, Payment & Healthcare Operations (3/03)

In this document, "I" and "my" refer to the patient.

I consent to the use or disclosure of my protected health information by Atlas Family Chiropractic, for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the clinic/practice. I understand that analysis, diagnosis or treatment of me by Atlas Family Chiropractic may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Atlas Family Chiropractic is not required to agree to the restrictions that I may request. However, if Atlas Family Chiropractic agrees to a restriction that I request, the restriction is binding on Atlas Family Chiropractic. I have the right to revoke this consent, in writing, at any time, except to the extent that Atlas Family Chiropractic has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Atlas Family Chiropractic and understand that I have a right that Notice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Atlas Family Chiropractic. The Notice of Privacy Practices for Atlas Family Chiropractic is also posted in the waiting room at 2310 Mildred St. W. Suite 130, University Place, WA 98466 and on the clinic website at http://atlaschiro.com/privacy_policy/. This Notice of Privacy Practices also describes my rights and duties of Atlas Family Chiropractic with respect to my protected health information.

Atlas Family Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Atlas Family Chiropractic and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Printed Name of Patient

Date of Signing

Description of Personal Representative's Authority

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(PLEASE PRINT) - All information will be strictly confidential.

Patient's Name (First, MI, Last)		Birth Date	Age	Sex M F	Marital Status M S W D DP
Residence Address	City	State	Zip	Home Phone ()	
Patient E-mail Address	If Child, Parent Or Guardian's Name		Height	Weight	
Name Of Employer	Address (with city, state and zip)		Business Phone ()		
Occupation	Patient's Social Security Number - -		Mobile Phone ()		
Emergency Contact	Relationship To Patient		Phone ()		
Whom May We Thank For Referring You To Our Office?			Phone ()		
Do You Have Medical Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	If No, How Do You Intend To Pay? <input type="checkbox"/> Check <input type="checkbox"/> Cash <input type="checkbox"/> Credit Card		Insurance Company Name, Address and Phone Number		
Subscriber's Name	Subscriber's ID Number	Group No.	Is It Through Your Employer? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name Of Spouse		Subscriber's Birth Date			
Medicare No.					
<p>CONSENT TO TREAT A MINOR: <i>I hereby authorize Atlas Family Chiropractic PS and whomever they designate as assistants to administer care to my</i></p> <p><input type="checkbox"/> son <input type="checkbox"/> daughter <input type="checkbox"/> grandson <input type="checkbox"/> granddaughter <input type="checkbox"/> _____</p> <p>(Name of Child) _____ Dated at (city) _____ (state) _____</p> <p>(Date signed) _____ (Signature) _____ (Witness) _____</p> <p>PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. <i>I authorize request of any medical information necessary to process this claim and request payment of government benefits either to myself or to the party who accepts assignment below.</i></p>					
Signed _____		Date _____			

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