

Rody
Chiropractic
Featuring Atlas Orthogonal

The Federal government is requiring that we ask you these questions as part of the law governing electronic health records.

Name: _____ Date: _____

Date of Birth: ____ / ____ / ____

What is your race? Please circle one:

American Indian or Alaska Native

Asian

Black or African American

Native Hawaiian or other Pacific Islander (*please specify*): _____

White/Caucasian

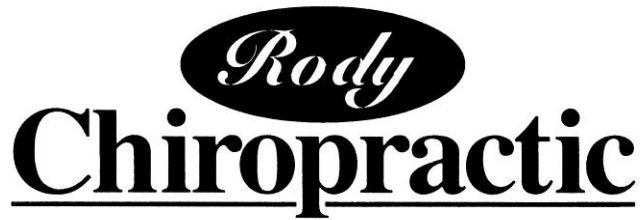
Multi-Racial

Other (*please specify*): _____

Decline to answer

Do you consider yourself to be of Hispanic or Latino ethnicity?

Please circle one: Yes No Decline to answer



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Rody Chiropractic & Massage Payment Plans

To All New Patients

Please initial next to your method of payment.

_____ **Cash/Private Pay Patient:** To receive our discounted rate, payment is required at the time services are rendered. If payment is not made at the time of service, you will be charged our full rate, which is currently \$71. We accept Visa, MasterCard, Discover Card and personal checks.

_____ **Insurance Patient:** You need to provide our office with your insurance information. We do not verify benefits, it is your responsibility to call your insurance company to verify that they will cover our doctors & x-rays. You should also know if you have a deductible & the amount of your co-pay, if any. We will bill your insurance as a courtesy to you, with the understanding that you are ultimately responsible for your account in our office. All co-pays are expected at the time of service. If you do not know what your copay is, you will be required to pay \$25 per visit until the correct amount of your copay has been determined.

_____ **Personal Injury Patient:** It is your responsibility to provide our office with any and all insurance information; including PIP, third party, health insurance, etc. We need all claim numbers and insured person's name, address, and phone numbers. You are responsible for payment to our office for any services rendered. We are happy to accept 3rd Party Claims; however you will be required to pay a one-time lien fee of \$124 up-front to guarantee payment on the account.

_____ **Labor & Industries Patient:** You are responsible for filling out Labor & Industries long form or the form for self-insured L&I. You are also to have an accident report filed with your employer. If your claim is not accepted, you will be responsible for your account balance.

_____ *****I understand that any missed massage appointments without 24 hour notice will incur a \$30 fee*****

Patient Signature

Date

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TERMS OF ACCEPTANCE

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 forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment 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 vertebrae in the spinal column which causes alteration of nerve function and 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 vertebral subluxation. 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 subluxation.

I, _____, have read and fully understand the above statements.

All questions regarding the doctors' objective pertaining to my care in this office have been answered to my complete satisfaction. I therefore, accept chiropractic care on this basis.

PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am not pregnant and the above doctors at Rody Chiropractic and their associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of Last Menstrual Period: _____

Patient Signature

Date

Gordon M. Rody, D.C., B.C.A.O., D.A.C.S. • Douglas M. Rody, D.C., B.C.A.O., D.A.C.S • Amy J. Rody, D.C.

10614 Canyon Road East • Puyallup, Washington 98373 • (253) 535-6006 • Fax: (253) 535-6226

www.rodychiropractic.com



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Notice of Privacy Practices

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 notice describing:

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

We may require your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment or reimbursement of the care that 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 other purposes without your consent or authorization.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical 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 Practice which fully explains your rights and our obligations under the law. We may revise our Notice from time to time. The effective date at the top right hand side of this page indicates the date of 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.

If you have any questions, concerns or complaints about the Notice or your medical information, please contact Patty Ann at our office (253) 535-6006 x306.

Patient Signature

Date

Rody **Chiropractic**

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FINANCIAL AGREEMENT

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time of your visit unless payment arrangements have been made in advance with our staff. We accept checks, MasterCard or Visa. We will be happy to process your insurance claim.

Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1% per month.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of UCR. UCR is defined as usual, customary and reasonable fees for this region.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as chiropractic care providers, our relationship is with you, not your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

No show or cancellation policy for massage: Same day cancellation or no show will be charged \$30.00. Sorry, no exceptions! If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

Patient Signature

Date

Gordon M. Rody, D.C., B.C.A.O., D.A.C.S. • **Douglas M. Rody, D.C., B.C.A.O., D.A.C.S.** • **Amy J. Rody, D.C.**
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PATIENT-DOCTOR AGREEMENT

The purpose of this agreement is to allow us to serve you more completely and to get the best treatment results in the shortest amount of time. It is our experience that those patients who adhere to the following agreement get the best results.

SIGNING IN:

When you arrive at our clinic, we ask that you sign in on our sheet. Please print your name. Patients will be called and assigned a treatment room in the order they arrive for their scheduled appointments. If you are late for your appointment (more than 15 minutes) or are not scheduled at that time, you will need to wait until we have an opening. When you go to the assigned treatment room, it is recommended that you lie down and relax on the adjusting table.

APPOINTMENTS:

We have set up a specific course of treatment for you care. A certain number of treatments in a set amount of time is required for us to achieve the results we both desire. If you need to change your appointment, we ask that you give us 24-hour notice and that you make another appointment in one week or less. If you have an emergency and cannot give us 24-hour notice, you may leave a voice message. While we allow walk-in patients, an appointment is preferred. Patients who choose to walk-in without an appointment will be placed in order behind those with a scheduled appointment and assigned a room as time permits.

NO SHOW OR CANCELLATION FOR MASSAGE:

Same day cancellation or no show will be charged \$30.00. Sorry, no exceptions!

UPSETS AND CONCERNS:

We are here to serve you. Please speak to your Doctor about any upsetting matters (long waits, staff insensitivity, etc.) We seek your comments to help us serve you and others better.

Patient Signature

Date

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RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS

PLEASE READ & SIGN THE FOLLOWING

I understand that health and accidental insurance policies are an arrangement between the insurance company and myself; that this office will prepare any necessary reports and forms to assist me in making collection from my insurance company; and that any amount authorized to be paid for given services is to be paid directly to the doctor's office and will be credited to my account upon receipt.

However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that should I suspend or terminate my care or treatment, any and all fees for professional services rendered to me will be immediately due and payable within 30 days. I also agree that any unpaid balance after 60 days will be charged a 1% fee per month or 12% per year interest.

I further agree that if it becomes necessary to send my account to collections, I will pay all attorney, court and collection fees, including a collection fee of \$30.00. I am also aware that there will be a \$25.00 service charge for any returned checks.

I hereby authorize the Doctor to treat my condition through the use of manipulation throughout my spine. It is understood and agreed the amount paid the Doctor, for X-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

Patient Signature

Date



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INSURANCE COVERAGE QUESTIONS (Please complete & return)

Name of Patient _____ Date of Birth _____

Name of insurance representative _____

1. Coverage of Chiropractic Services

Number of visits per year: _____

Chiropractic X-Ray Coverage: _____

% of Regular Office Call Covered: _____

Co-Pay? _____

How much is my deductible? _____

Has my deductible been met this year? _____

Effective date of policy: _____

(A \$25 COPAY IS REQUIRED AT EACH VISIT UNTIL THIS COMPLETED FORM IS RETURNED.)

2. Massage Coverage

Number of massages allowed per year: _____

Length of time allowed for massage (30 min, 60 min etc) _____

Co-Pay? _____

Referral required? (from Chiropractor or MD?) _____

Is your massage covered by a Licensed Massage Practitioner, Chiropractor or Physical Therapist?
(Please circle all covered practitioners)

Names of massage therapists covered under my plan:

_____ Mel Ruchalski _____ Sabrina Laville _____ Joe Warness

_____ Haley Tracey _____ Lynetta Bogrand

_____ Signature _____ Date