Champion Chiropractic and Wellness Center, Inc.
Heart Sound Recorder Intake Form
Lexi Sandifer, FNTP

Patient _____
Last Name First Name Initial

Street Address _____ City _____ State _____ Zip _____

Home Phone ( ) _____ Cell (_____) _____ Work (_____) _____

Current Symptoms - Please Mark Each Symptom You Have

Tingling or Numbness	Chest Pain	Valve Replacement	Breathless with Activity
Dizziness	Mental Confusion	Flushed Cheeks	Trip/Fall Easily
Fatigued	Lack of Stamina	Lack of Motivation	Depression
Digestive Issues	Difficulty Swallowing	Hear Heartbeat in Ear	Pain in Shoulders
Pain in Arms	Pain in Neck	Pain in Back	Pain in Jaw
Pain in Throat	Palpitations	Weakness	Nausea
Sweating	Anxiety	Irregular Heartbeat	Pounding in Chest
Difficulty Catching Breath	Swelling/Edema	Rapid Weight Gain	Chronic Cough
Cold Extremities	Recurrent Infections	Fainting	Low Grade Fever

Other: _____

How frequently do you exercise? _____

What forms of exercise do you do? _____

Are you on a specific diet? _____

Consumption of caffeinated beverages? Yes ___ No ___ How much per day in cups? _____

Do you consume mineral salt? Yes ___ No ___ or Salt Free Diet ___

Have you ever played sports or participated in dance/gymnastics/cheer? Yes ___ No ___
Please List: _____

Have you ever had any moderate to severe head injuries that may include concussion, stitches, or monitoring after the accident? Yes ___ No ___

Scale 1 - 10, with 10 being the worst, what is your current stress level? Please circle:

1 2 3 4 5 6 7 8 9 10

Have you ever worked around power lines or other sources of electricity? Yes ___ No ___

Do you wear a FitBit? Yes ___ No ___

Do you work around WiFi all day? Yes ___ No ___

Do you have a Smart Meter on your home? Yes ___ No ___

Is your home over 30% wireless? Yes ___ No ___

Women

Breast Pain ___ Wear Underwire Bras ___ Low Sex Drive ___

Men

Inability to Get/Maintain Erection ___ Inability to Achieve Orgasm___ Prostate Issues ___ Low Sex Drive ___

Do you have silver or gold fillings, implants, or other oral devices? Yes ___ No ___

Do you have any metal staples, appliances, or replacement parts in your body? Yes ___ No ___

Please list all surgeries: _____
_____

Please list current medications, supplements, herbs, homeopathy, or essential oils: _____
_____
_____
_____

Please list all medical diagnosis: _____
_____
_____

Family medical history: _____
_____
_____
_____

Have you had SARS Cov 2 (Covid 19)? Yes ___ No ___

Did you have a positive Covid Test? Yes ___ No ___

If yes, when? _____

Have you had the mRNA (Covid) shot? Yes ___ No ___

If yes, which one? _____

If yes, when? _____

Have you not felt well in any way since your shot? _____

If yes, what have you been experiencing? _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Heart Sound Recorder Patient Consent Form

I give _____ permission to record the sound of my heart and to create a graph of that sound on the Heard Sound Recorder (a general wellness cardiac stress monitor). I have been informed and understand that the Heart Sound Recorder is not an electrocardiograph like those in hospitals or physicians and that it is not capable of diagnosing heart conditions and is not in any way a substitute for such a device. I further understand that the Heart Sound Recorder has not been reviewed or cleared by the US Food and Drug Administration. I understand that if I have or believe I have a heart condition, that I should see a physician qualified to evaluate and treat that condition.

Any suggested nutritional or dietary advice is not intended as treatment or therapy for any disease or symptom of disease. Nutritional counseling, supplement recommendations, and exercise considerations provided to me are to support the normal physiological processes of the body.

I understand that any techniques, treatments, or lifestyle changes suggested after the use of this device should be undertaken only with the guidance of a licensed physician, therapist, or healthcare practitioner.

The findings from this device can be used to support, but should not be used in place of sound medical therapies and recommendations.

I am giving permission to _____ to share my graph with other practitioners for educational purposes only so long as my name and other personal information are removed.

By signing below, I agree to the above.

Print Name: _____

Signature: _____

Date: _____

Champion Chiropractic and Wellness Center, Inc.
Financial Policy

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately each visit you were seen for, the payments made by your insurance company to those dates, any contract adjustments, other adjustments if applicable, co-pays and other payments you have paid, and finance charges, if any. For any balance paid the previous billing cycle, these visits will not appear on future statements.

Payment if you have no insurance: Payment is due in full at the time of service for each service that you have per office visit.

Payment if you have insurance: We will bill your insurance if we are providers with them. Please check with us or your insurance company to see if we are providers. Not all of our providers are contracted with the same insurance companies. You are responsible for all charges not paid by your insurance company.

Payments: Unless other arrangements are approved by us, the balance on your statement is due and payable when the statement is issued, and is past due if not paid at the time of service.

Charges to Account: We have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Contracted Insurances: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a copay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or pre-authorization, you are responsible for obtaining it. Failure to obtain the referral and/or pre-authorization may result in a lower payment or denial of payment from the insurance company. You are responsible for all charges not paid by your insurance company.

Non-Contracted Insurances: Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You are responsible to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or authorization, you are responsible for obtaining it. Failure to obtain the referral and/or pre-authorization may result in a lower payment from the insurance company.

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within 30 days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of 1% per month **ANNUAL PERCENTAGE RATE** of 12% or $5.00 per month, whichever is larger. The finance charge on your account is computed by applying the periodic rate to the overdue balance of your account. The overdue balance of your account is calculated by taking the balance owed 30 days ago and then subtracting any payments or credits applied to the account during that time.

Required Payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we must receive copays at the beginning of your visit. Unpaid copays will result in a $10 billing fee added to your monthly statement.

Returned Checks: There is a fee for any checks returned by the bank. Currently, this fee is $60.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collections cost which we incurred. If we have to refer a collection of the balance to a lawyer, you agree to pay all lawyer's fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Thurston County, Washington.

Champion Chiropractic and Wellness Center, Inc.
Financial Policy

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to the credit reporting agency, the fact that you receive treatment at our office may become a matter of public record.

Divorce: In the case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After the divorce or separation, the parent authorizing treatment for a child will be the parent responsible for the subsequent charges. If the divorce requires the other parent to pay for all or part of the treatment cost, it is the authorizing parent's responsibility to collect from the other parent.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee, if you want to have copies of your records sent to another doctor organization. The amount of the fee is dependent on the number of pages we need to copy. You authorize us to include all relevant information, including your payment history. If you're requesting your records to be transferred from another doctor organization to us, you authorize us to receive all relevant information, including your payment history.

Worker's Compensation: We require a written approval/authorization or your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you'll be responsible for payment in full.

Personal Injury: Our financial relationship is with you, not your insurance company. It is imperative that you understand that you are the one ultimately responsible for your bill. It is the patient's responsibility to dispute your insurance company's decision by calling your claims manager. If your insurance company has not made a payment within 60 days or is withholding payment, for any reason, you will be personally responsible for any outstanding balances on your account. You also authorize Champion Chiropractic Center, Inc. to turn your claims into the Washington State Insurance Commissioner for assistance on payment of unpaid claims. If you reach the maximum benefits for your personal injury claim, you'll be responsible for obtaining an attorney before any further treatment is provided. You will also be responsible for making a minimum monthly payment on your account until settlement of your claim. A payment plan will be created by the financial manager to meet patient and office needs.

Printed Name: _____ Date: _____

Signature: _____ Office Manager Initials: _____

Champion Chiropractic and Wellness Center, Inc.
Missed Appointment Financial Policy

Our doctors and therapists value your time and request that you value their's. We make every attempt to respect our patient's time by scheduling appropriate times for treatment and minimizing the amount of time a patient waits for care.

Everyone at Champion Chiropractic Center works very hard to provide excellent customer service. Since missed and late appointments greatly interfere with our ability to care for our patients, we have the following policies:

If a patient is unable to keep their scheduled appointment, they must notify the office 24 hours in advance for Chiropractic, Massage Therapy, Cold Laser Therapy, and Clinical Nutrition.

Appointments canceled the same day as they are scheduled is considered a missed appointment. While calling just before your appointment time is better than not showing up, the end result is the same.

If a patient arrives more than 10 minutes late for an appointment, they have missed their appointment. We will try to fit them in around other scheduled patients, but it may involve a wait.

Your failure to notify the office of your intention to cancel and reschedule within the listed time frame, for each profession, will result in the following fees:

- Chiropractic $52.00
- Cold Laser Therapy $52.00
- Clinical Nutrition $52.00

Please Note: Missed appointment fees must be paid at the next scheduled appointment. Medical Insurance, Auto Insurance, and Workers Compensation **WILL NOT** cover these charges.

All fees are subject to monthly finance charges. All fees are subject to change without notice.

Printed Name: _____ Date: _____

Signature: _____ Office Manager Initials: _____

Champion Chiropractic and Wellness Center, Inc.
Receipt of Privacy Practices

Your healthcare information is state mandated to be kept private from any and all parties. Champion Chiropractic Center, Inc. has a brochure that tells me how my health information is taken care of. This brochure is called "Notice of Privacy Practices." Champion Chiropractic Center, Inc. provided me with the most current "Notice" and may update this "Notice" at any time. Any updates to the "Notice" will be posted in the office. Please initial each statement that you agree upon:

1. _____ I have been given a current brochure of the "Notice of Privacy Practices which describes how my health care information will be used and disclosed to carry out treatment, payment, and health care options.

OR

2. _____ I have been informed how my health care records and information will be kept private, and I choose not to take a brochure at this time.

ALSO

3. _____ I give Champion Chiropractic Center, Inc. staff permission to call me on the phone to make reminder calls or to discuss my account information.
4. _____ I agree that messages may be left on my answering machine or voicemail.

The following people may obtain my medical information in case of my absence, hospitalization, or incapacitation:

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

_____ _____

Patient or Legally Authorized Individual Signature Today's Date

_____

Relationship to patient if signed on behalf of the patient by parent, legal guardian, etc.

HOW TO PREPARE
FOR A HEART SOUND RECORDER SESSION

1. No caffeinated beverages 3 hours prior to your test.
2. Drink 2 cups of water at least 1 hour before your test.
3. Do not take any supplements 2 hours prior to your test.
4. Do not eat 1.5 hours before the test.
5. Please wear a shirt/blouse that is thin. The recorder cannot read through thick fabric.
6. Women- please wear a soft cup bra or sports bra.
7. Please remove FitBit or Apple watches 1 hour before the test.
8. Please remove watches, necklaces, earrings, money clips or any other metal devices and jewelry that can be removed.
9. Cell phones are not allowed in the testing room.

For each person that you refer for a Heart Sound Recorder session, you will receive a $10.00 referral credit that can be applied <u>either</u> to a supplement purchase <u>or</u> to your office visit fee. This is our way of saying "Thank You" for having such a great heart for your family & friends!

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