Champion Chiropractic and Wellness Center, Inc.
Cold Laser Therapy - Adult Patient Registration Form

Patient Information **Date:** _____

Patient Name: _____ _____ _____
Last First Middle Initial

Nickname:_____ Email:_____

Address: _____
Street Address City State Zip Code

Date of Birth: _____ Phone: ( ) _____ Work: ( ) _____

Occupation: _____ Employer/School: _____

In Case of Emergency, Contact: _____ Relationship: _____

Emergency Contact Number: ( ) _____

Who may we thank for referring you? _____

Assignment and Release

I certify that I, and/or my dependents, have insurance coverage with _____ and assign directly to Dr. Sandifer all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose said information to the above named insurance company, the Washington State Insurance Commissioner, and their agents for the purpose of obtaining payment for services, handling disputes, and determining insurance benefits payable for related services.

_____ _____
Name of Financially Responsible Party **(Please Print)** Signature of Financially Responsible Party

_____ _____
Relationship to Patient Today's Date

Champion Chiropractic and Wellness Center, Inc.
Laser Therapy Informed Consent & Contraindication Form

I hereby request and consent to the performance of Class IV Laser Therapy treatment by Dr. Steven Sandifer and/or his preceptor and/or other licensed doctors of chiropractic or a certified technician of Champion Chiropractic Center, Inc. who now, or in the future, treat me while employed by, working or associated with, or serving as a back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I understand that class IV Laser Therapy treatments are a medical treatment that uses specific wavelengths of light to impart energy into injured cells and tissues. This energy is transformed from photon energy to biochemical energy in the cells which can then be used in the repair processes in the body. The expected direct outcomes from laser treatment may include reduced inflammation, reduced pain, and repair of tissues. The indirect outcomes may include increased ranges of motion, comfort and activity levels. Alternatives to Class IV Laser Therapy treatments include, but are not limited to, chiropractic care, massage therapy, physical therapy, exercise therapy, anti-inflammatory or anti-pain medication, ultrasound, physiotherapy, mental health counseling, or drug therapy.

I have had an opportunity to discuss with the doctor named above and/or other office or clinic personnel the nature and purpose of the Class IV Laser Therapy Treatments. I understand and am informed that, as in the practice of medicine, in the practice of Class IV Laser Therapy there are some risks to treatment including, but not limited to:

- **Short Term Effects:** I understand that there are multiple short-term effects that may occur, including reddening, irritated raised rash, mild burning, swelling, bruising, numbing, temporary pigmentary change, blistering, scabbing, crusting, flaking, and sensitivity to the sun. Although these effects typically resolve within several days, they may persist for several weeks and rarely, even longer. I understand that the degree of the side effects varies from person to person, and it may not be possible to predict how I will respond.

- **Possible Permanent Effects:** I understand that although most side effects are short term and resolve fairly quickly, some effects may be permanent. Scarring, changes in pigmentation and hair loss may be permanent.

- **Discomfort Associated With Procedure:** I understand that the laser functions by heating up the targeted area (blood vessels, pigmentation, etc.). This heating sensation is minimized by the use of cool towels, but some level of discomfort may be felt. The level of discomfort depends on the treatment being done, and varies from person to person. The stinging or sensation of heat is typically short, but may persist for several hours after the procedure.

- **People Excluded From Therapy**: I understand that certain patients should not have laser treatment. This includes any patients who have open wounds, malignant skin tumors, patients who have certain diseases that makes them sensitive to light, patients currently on Accutane (Isotretinoin) or who have been on Accutane within the last 3 months, and in many cases, patients who have tattoos.

- **Need for Multiple Treatments:** I understand that some conditions being treated by the laser may require multiple treatments that may take 6 months to a year to obtain the desired results. Everyone responds in different ways and different rates to the treatment.

- **Tattoo/Permanent Makeup:** If there are any tattoos or permanent makeup in the area, there is a possibility of blistering and lightening of the tattoo/makeup.

- **Photographs or Video:** I understand photos or video of my treatment may be taken. These may be used for teaching health professionals or shown for scientific reasons. I will NOT be identified in any photo or video without my informed consent.

- **I Agree To Wear Proper Eyewear:** Eye injury due to the use of the laser is a risk to the patient and to the clinician, however, the risks are almost completely eliminated with the use of proper eyewear. I understand that Class IV Therapy Lasers emit both visible and invisible light. Protective eyewear is necessary at all times during the treatment. I will not remove the Safety Goggles until the administrator of the laser has turned off the laser treatment and provided notification that it is safe to remove them. You may be asked to remove reflective objects, such as rings, metal watch bands, cell phones, and jewelry prior to treatment with the laser.

- **I Understand That This Procedure is Elective** and there are other options for treatment, including no treatment.

- **I Understand That Medical Insurance Will NOT Cover the Cost of Class IV Laser Therapy**, and I am responsible for the complete cost of service. Payment is due at the time of the treatment unless other arrangements have been made in advance**I Understand That the Risks of Not Having Laser Treatments Include, But Are Not Limited To:** ongoing pain and inflammation, development of scar tissue, development of degenerative changes, and reduction in daily activities and overall comfort.

Contraindications To Class IV Laser Therapy

Please answer the following questions:

Are you pregnant? Yes ___ No ___
Do you have cancer? Yes ___ No ___
Have you had cancer within the past 12 months? Yes ___ No ___
Are you currently taking any photosensitizing medications? Yes ___ No ___
Are you currently using any photosensitizing essential oils? Yes ___ No ___
Can you be in the sun for 10-15 minutes without having itchiness, redness, blotchiness, or pigmentation issues? Yes ___ No ___

Class IV Laser Therapy Precautions

Do you have one or more of the following?

Do you have a pacemaker or other implanted medical device (morphine pump, neurostimulator, etc.)? Yes ___ No ___
Have you had steroid injection(s) within the past 7 days? Yes ___ No ___
If yes, where on your body was the injection? _____
Is your pain directly over an epiphyseal plate (growth plate) in children under the age of 15 years old? Yes ___ No ___
Is your pain over the Ovaries, Testes, or Thyroid Gland? Yes ___ No ___

I have read, or have had read to me, the Informed Consent to Class IV Laser Therapy Treatment. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the above-named procedure. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

Patient Name:_____ Date:_____

Patient Signature:_____ Date:_____

Guardian Name:_____ Date:_____

Guardian Signature:_____ Date:_____

Laser Technician:_____ Date:_____

Laser Technician Signature:_____ Date:_____

Champion Chiropractic and Wellness Center, Inc.
Confidential Patient Complaint Form

Date: _____

First Name: _____ Last Name: _____

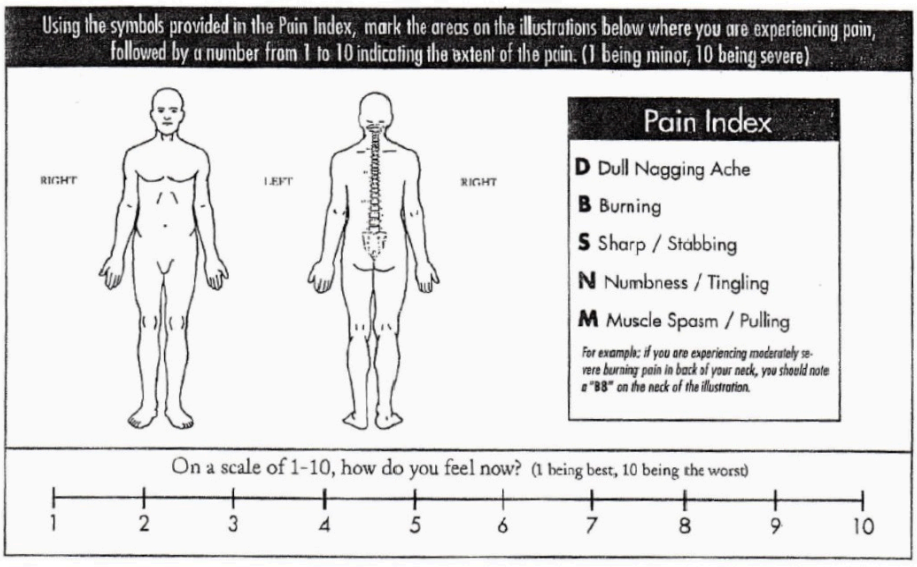
Major Complaint Information

What is your major complaint(s) and specific area(s) of pain? _____

_____

When did this symptom(s) begin? _____

If this is an injury, describe what happened? _____



Have you experienced these symptoms before? Yes ___ No ___ When? _____

What aggravates this condition? _____

What decreases the symptoms/pain? Ice ___ Heat ___ Stretching ___ Nothing ___ Other _____

Have you seen another doctor for this condition? Yes ___ No ___ Doctor's Name: _____

Date consulted: _____ Diagnosis: _____

Does this condition interfere with your sleep? Yes ___ No ___ If so, how many times do you wake up in pain per night? _____

Do you wear a heel lift? Yes ___ No ___ If so, which side? Right ___ Left ___

Does it cause pain to cough, grunt, sneeze? Yes ___ No ___ If so, where? _____

Check the activities below that create difficulty or pain:

____ Lying on back	____ Getting in/out of car	____ Pulling	____ Sitting	____ Standing for periods of time
____ Lying on side	____ Dressing self	____ Reaching	____ Bending forward	____ Sneezing
____ Turning over in bed	____ Sexual activity	____ Kneeling	____ Bending backward	____ Coughing
____ Lying on stomach	____ Pushing	____ Stooping	____ Walking	____ Turning head side to side
____ Climbing stairs	____ Balance	____ Gripping	____ Chewing	

Other: _____

Does the pain radiate into the legs? Yes ___ No ___ Right ___ Left ___ Both ___ Does the pain radiate to the abdomen? Yes __ No __

Do you ever have impairment of bowel or urinary function? Yes ___ No ___ Explain: _____

Do you have numbness or tingling in the legs? Yes ___ No ___ Explain: _____

Medical Information

Have you ever had any surgeries or hospitalizations? Yes ___ No ___ Please List Below:

Type of Hospitalization / Surgery / Transplants	Date	Type of Hospitalization / Surgery / Transplants	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you had spinal x-rays in the last 12 months? Yes ___ Not Sure ___ When? _____ What views were taken? _____

Have you been seen by a chiropractor before? Yes ___ No ___ Name:_____ Date:_____

Do you have a family physician? Yes ___ No ___ Name:_____ Phone:_____

Address: _____ City:_____ State:_____ Zip:_____

Family Medical History: Please list any diseases or medical problems of siblings, parents, and grandparents:_____

_____

Have you ever had: ____ Motor Vehicle Injury ____ Work Injury ____ Slip and Fall Injury If yes, please explain:_____

_____

Additional Complaints and Diagnosis

Please check all that apply to you

___ Loss of Concentration	___ Shortness of Breath	___ Cold Hands	___ Arthritis	___ Autistic
___ Cold Feet	___ Cancer	___ Jaw Pain	___ Leg Pain	___ Speech Difficulty
___ Upper Back Pain	___ Stroke	___ Fatigue	___ Dizziness	___ Nausea
___ Heavy Feeling of Head	___ Mid Back Pain	___ Hypertension	___ Snore	___ Asthma
___ Right/Left Shoulder Pain	___ Insomnia	___ Seizures	___ Nervousness	___ Headaches
___ Ringing in Ears	___ Sinus Problems	___ Heart Disease	___ Bi-Polar	___ Seizures
___ Loss of Balance	___ Right/Left Arm Pain	___ Heart Palpitation	___ Arthritis	___ Crohn's
___ Pins & Needles	___ Hand/Finger Numbness	___ Pain Behind Eyes	___ Migraines	___Thyroid Condition
___ Loss of Smell	___ Feet/Toe Numbness	___ Digestive Trouble	___ Lung Issues	___ Fibromyalgia
___ Sleep Disruption	___ Lung Condition	___ Heart Condition	___ Emphysema	___ Neuropathy
___ High Blood Pressure	___ Alzheimer's / Dementia	___ Bladder Disease	___ Kidney Disease	

Any Other Complaints and Diagnosis:_____

_____

Any additional information you would like the doctor to know about before beginning care at Champion Chiropractic Center, Inc.: _____

_____

_____

I certify that the above information is correct to the best of my knowledge. By the signature below, I hereby authorize and consent to chiropractic treatment by Dr. Steven Sandifer of Champion Chiropractic Center, Inc. A photocopy of this authorization shall be considered valid as the original. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose said information to my insurance company, the Washington State Insurance Commissioner, and their agents for the purpose of obtaining payment for services, handling disputes and determining insurance benefits or the benefits payable for related services. I authorize that all payments go directly to Dr. Steven Sandifer.

Patient/Guardian Signature: _____ Relationship to Patient: _____

Please Print Name: _____

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.

Missed Appointments: Our doctors & 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. 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 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 fee:

- Chiropractic: $52.00
- Cold Laser Therapy: $52.00
- Massage Therapy: $60.00
- 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.

Printed Name: _____ Date: _____

Signature: _____

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.