Southcenter Wellness ● 662 Strander Blvd. Tukwila, WA 98188 ● Office: (425) 204-1575

New Patient Registration

Please note that all information is strictly confidential.

Please help us to provide you with a thorough evaluation by taking the time to fill out this form carefully. Here at this office we offer chiropractic, massage and acupuncture. The health information you provide can be used for any of those services. If we believe that we cannot assist you with your health care needs, we will be more than happy to refer you to the appropriate health care professional. If you have any questions, please let us know. Thank you.

First Name: ________________________ Nickname: ________________ Middle Initial: ______________

Last Name: ____ **Gender:** ☐ Male ☐ Female

Date of Birth: ______/______/______ Age: ________ **Social Security #:** ____________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner

Address: ________________________________ **City/State/Zip:** ____________________________

Home Phone: __________________ **Work Phone:** __________________ **Cell Phone:** __________________

Primary Contact Number: ☐ Home ☐ Work ☐ Cell **Cell Phone Carrier**: __________________

E-mail address: ____

Occupation: ______________________________________ **Employer:** ________________________

Primary Care Physician: ______________________________________ Phone: ____________________

Spouse: ______________________ Children & Ages: ____

In Case of Emergency, Contact: ____

Relationship: ______________________________________ *Phone:* ____________________________

How did you hear about our office/whom may we thank for referring you?: ______________________________

Seeking treatment due to an injury? ☐ Yes ☐ No If yes, ☐ Auto ☐ Work ☐ Other ________ Date of Injury: __________

Insurance Information

Primary Insurance: ☐ None ☐ Health/Medical ☐ Automobile ☐ L&I/Workers' Compensation

Name of Insurance Company: ______________ Prefix: _____ ID#: ________________ Group #: ______________

Name of Insured: ______________________________ Relationship to Patient: ____________________________

Secondary Insurance: ☐ None ☐ Health/Medical ☐ Automobile ☐ L&I/Workers' Compensation

Name of Insurance Company: ______________ Prefix: _____ ID#: ________________ Group #: ______________

Name of Insured: ______________________________ Relationship to Patient: ____________________________

I understand that any quotation of benefits is NOT a guarantee of payment, and the agreement is between the Insurance Carrier and me. I authorize any and all payments from my insurance carrier directly to this office with the understanding that all monies be credited to my account upon receipt. Any denial of payment becomes my responsibility (patient).

I certify that the above information is correct and true.

Patient/Guardian Signature: ____________________________________ **Date:** ____________________

Patient Name:________________________________

Privacy Practices

By signing below, I acknowledge that I received a copy of the Notice of Privacy Practices for Southcenter Wellness. This Notice describes how Southcenter Wellness may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information and rights I may have regarding my protected information.

________ **Initials**

Consent to Treatment

By signing below, I hereby request and consent to the performance of chiropractic, nutritional and other procedures, including, massage therapy, acupuncture, rehabilitation exercises and diagnostic tests, on me (or the patient named above, for whom I am legally responsible) by the licensed practitioner(s) who now or in the future work at Southcenter Wellness. I have had the opportunity to discuss with the practitioner(s) and/or with other office personnel the nature and purpose of treatments and other procedures. I understand that results are not guaranteed. I understand and am informed that, in the practice of chiropractic and other applicable methods of treatment, there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the practitioner(s) to be able to anticipate and explain all possible risks. I wish to rely on the practitioner(s) to exercise judgment during the course of the procedure which the practitioners(s) feels at the time, based upon the facts then known to him or her, is in my best interest. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I hereby authorize the doctor(s) at Southcenter Wellness and staff to administer treatment as they so deem necessary.

________ **Initials**

Appointment Policy

By signing below, I understand that a fee of **$35** will be charged to my account for massage and acupuncture appointments missed or cancelled **without 24 hours advanced notice**. I understand that if I am using a gift certificate as my method of payment, my gift certificate will be used as payment and my appointment will be forfeited.

To better assist you and maximize results, please refrain from smoking one hour before and one hour after an appointment. As always, the longer you can refrain from smoking before and after, the more beneficial it will be for your treatment and health. For the best experience for you and your practitioner, please shower the day of your appointment. Thank you for your cooperation in this matter.

________ **Initials**

Fees and Authorizations

By signing below, 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 I am responsible for payment of all deductibles and co-payments related to my care if treatment is billable toward my insurance carrier. It is my understanding that my credit may be checked if Southcenter Wellness extends credit to me. I understand that if I have a balance for medical services not paid I may be charged interest on any past due balance at a rate of 12% per year. I understand that if my treatment is associated with a personal injury or accident claim, all medical bills will be paid at 100% of the fee schedule regardless of the outcome of my case. I understand that if a check or debit is returned for insufficient funds, I will be charged a $35.00 service charge.

________ **Initials**

Patient/Guardian Signature:____ Date: _________________________