Dr. Greg Chong Lee, DC

11734 15th Ave NE
Seattle, WA 98125
(206) 364-9501

Seattle Northeast
CHIROPRACTIC

Name:____ Date:__________________
(First/Middle/Last)

Birthdate:_________________ Sex: M_____ F_____ Phone Number: ____________________

Address:____________________________________ City & ZIP: ______________________

Appointment Reminder: ❐ TEXT ❐ EMAIL Phone Carrier: ______________________

Email Address: ______________________________ Referred by: ______________________

Employer: __________________________________ Occupation: ______________________

Current Complaint:____

When did it start? ____________________________________ Is it: ❐Worse ❐Better ❐Same

Doctors seen for this condition: ____

Treatment Results: ❐ Good ❐ Fair ❐ Poor

Had this condition before? ❐ Yes ❐ No Are you pregnant? ❐ Yes ❐ No

Surgeries:____

Falls/Broken bones:____

Prior car accidents:____

Medications:____

Have you seen a Chiropractor before? (Give dates)__________________________________

Have you ever had any of the following? (Check all that apply)

❐ Scarlet Fever	❐ Bowel problems	❐ Kidney disease	❐ Prostate problems	❐ Pneumonia
❐ Diabetes	❐ High blood pressure	❐ Urinary problems	❐ Rheumatic fever	❐ Nervousness
❐ Allergies	❐ Backaches	❐ Diverticulitis	❐ Swollen Ankles	❐ Other__________
❐ Cancer	❐ Dizziness	❐ Low blood pressure	❐ Ulcers	__________
❐ Hemorrhoid	❐ Lung disease	❐ Headaches	❐ Migraines	__________

Insurance Company:____________________________________ ID#:______________________

If not insured, person responsible for payment: ____

(Please give your insurance card and ID to the front desk assistant to be copied)

Emergency contact: ____________________________________

Relationship______________________ Phone: ______________________________

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Ultimately it is my responsibility to be aware of my insurance benefits and coverage and that all charges incurred are ultimately my responsibility. I realize this office will prepare any necessary reports, forms and/or bills to assist me in making collections from the insurance company, and that any amount paid will be credited to my account upon receipt. If payment is sent to me by my insurance company, I agree to make an equal and prompt payment to Seattle Northeast Chiropractic. I also understand that this office reserves the right to attach interest in the amount of the 12% per annum (1% per month) to any account 60 days past due, and to charge me for appointments missed without 24 hours previous notice. I authorize Seattle Northeast Chiropractic to request and receive any and all medical records, chart notes and x-rays, which may be deemed necessary, from previous physicians. I authorize this office to endorse checks made out to me from my insurance company for payment of my account only.

Signature: ____ Date: __________________

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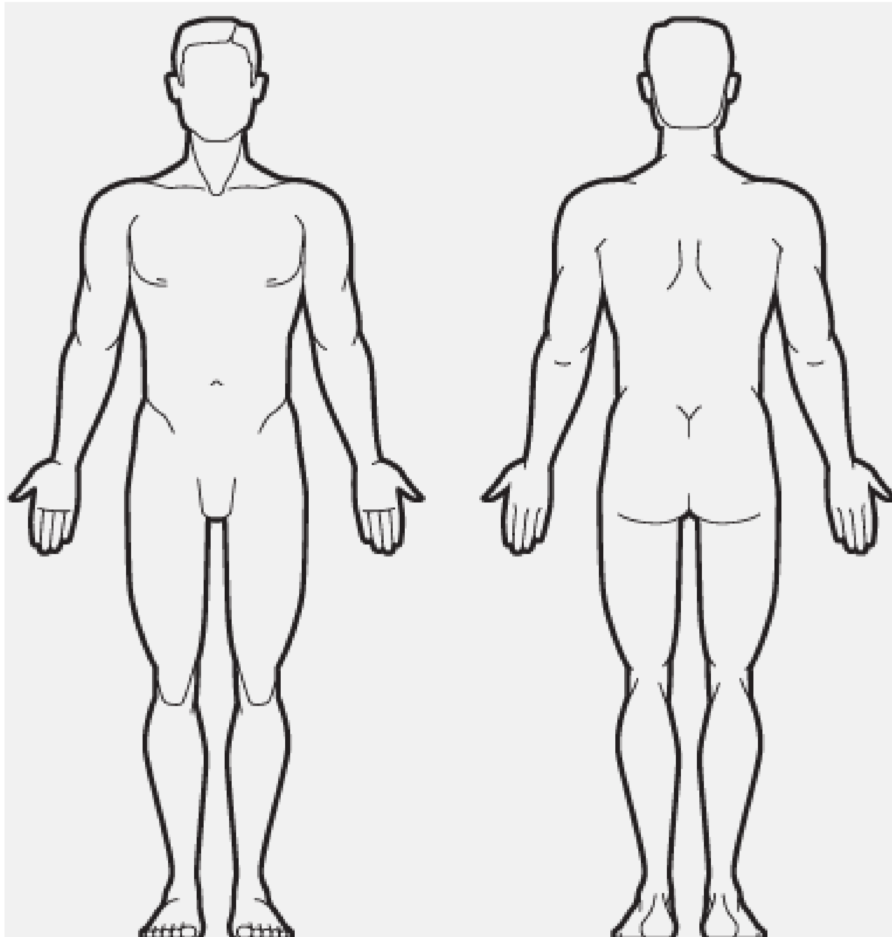
Seattle Northeast CHIROPRACTIC

Pain Drawing

Name: ____ **Date**: ____________________________

Please be sure to fill this out accurately. Mark the area on your body where you feel the described sensation(s). Use the appropriate symbol(s) to mark areas of radiating pain and include all affected areas.

Numbness	Pins & Needles	Burning Pain	Stabbing Pain	Aching Pain
- - - - -	OOOOO	XXXXX	/ / / / /	(((((



Visual Analogue Scale

Please mark on the line the pain level that most accurately represents your pain:

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (UNBEARABLE PAIN)

Right Now: ____

Average Pain: ____

At Best: ____

At Worst: ____

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Seattle Northeast CHIROPRACTIC

Financial Policies Agreement

Patient Name: _______________________________________ Patient Number: _______________

Patients with Commercial Insurance: As a courtesy, we will bill your insurance for services rendered in this office for you. We will check on your benefits prior to receiving care, however, a verification of benefits does not guarantee services will be covered, this will be determined by your insurance company after the claims have been submitted and then processed by the insurance company. This will be explained in further detail on our Insurance Verification Form. Insurance is a contract between the patient and their carrier, and any payment is ultimately the patient's financial responsibility.

IN-NETWORK - This status means that the practice and provider (doctor or massage therapist) are contracted with your insurance company. Covered services that are approved by your insurance company will be submitted for payment. If you have a copay, that fixed amount will be due on the day services are rendered. If you have coinsurance or an unmet deductible that applies to the services, your payment will be due after your insurance company processes your claim(s) and remits payment to our office, followed by an explanation of patient benefits. We will then send you a statement reflecting your financial responsibility. You will be responsible for your coinsurance percentage or 100% of the services if your deductible does apply. Your payment will be due 30 days from the statement date for the amount listed at the bottom of that statement. If your account balance is not paid in full by 90 days after your last date of service, we may turn your account over to our collection agency and a collection fee of $50 will apply, unless other payment arrangements have been approved. Initials:________

OUT OF NETWORK - As a courtesy, we will verify with your insurance if you have out of network benefits. If you do have this insurance benefit, it means that your insurance company will cover services rendered in this office and we may bill your insurance on your behalf. The difference is possibly a higher copay, higher coinsurance percentage or unmet deductible without the in network contracted price. *Payment regulations as noted in "in network" will apply to insurance verified "out of network" patients*. If you do not have the "out of network" benefit, payment for services rendered will be due on the time services are rendered. (please see Non-Insurance Patients for policy) Initials:________

Non-Insurance Patients: You will be required to pay for your services on the day and time they are rendered. Many patients prefer to pay for the recommended course of treatment up front and this is always welcomed. If your provider finds that you are not in need of the additional treatment that was initially recommended for any reason, we will refund only the amount for the services that will not be rendered. If treatment would be of a financial hardship, please inquire our office manager, as some cases may be approved for financial discounts. A separate agreement form will apply for any financial discounts.

Signature: ____ **Date**: ______________

Staff Initials: _________

Dr. Greg Chong Lee, DC

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Seattle Northeast
CHIROPRACTIC

Informed Consent for Chiropractic Treatment

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. 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. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic. Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, your chiropractor may recommend various techniques and services to assist in the correction process.

Throughout the course of your treatment, if we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider and we will provide you with the applicable referral document.

All questions and/or concerns regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and 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 Dr. Lee and his associates have my permission to perform an x-ray evaluation, I have been advised that x-ray can be hazardous to an unborn child. Initials:_________

Consent to examine and treat a minor child:

This is to certify that I, ________________________________, being the parent or legal guardian of ________________________________, have read and fully understand the above **Informed Consent** and hereby grant permission for my child to receive chiropractic care. Initials:_________

Patient Name: ____ Date of Birth: ________________________

Signature: ____ Date: ___________________________

Staff Initials: _________

Dr. Greg Chong Lee, DC

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Seattle Northeast CHIROPRACTIC

Notice of Privacy Practices 1/2

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Seattle Northeast Chiropractic and Dr. Greg Chong Lee, DC is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information Treatment:
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations (example):

"On occasion, it may be necessary to seek consultation regarding your treatment from other health care providers associated with Seattle Northeast Chiropractic."

"It is our policy to provide a substitute health care provider, authorized by Seattle Northeast Chiropractic, to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness or other emergency situation."

Due to the nature and proximity of Seattle Northeast Chiropractic's front lobby and treatment rooms, others may overhear conversations between the doctor and patient although every effort will be made to avoid loss of confidentially. At any time, you may request a private consultation with the doctor.

Payment:
We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example):
"As a courtesy to our patients, we will submit an itemized statement to your insurance center for the purpose of payment to Seattle Northeast Chiropractic for health care services rendered. If you pay for your health care services personally, we will, as a courtesy to you, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information including diagnosis, date of injury or condition, and codes which may describe the medically necessary care services received."

Change of Ownership:
If Seattle Northeast Chiropractic, PLLC is sold or merged with another organization, your health information will become the property of the new owner. If you were a prior patient of Dr. Leo G Studzinski, DC your health information may be disclosed to Dr. Greg Chong Lee, DC for purpose of proper documentation and diagnosis of your past medical history.

Worker's Compensation:
We may disclose your health information as necessary to comply with State Workers Compensation Laws.

Emergencies:
We may disclose your health information to notify or assist in notifying a family member or another person responsible for your care about your medical condition or in the event of an emergency or your death.

Public Health:
As required by law, we may disclose your health information to public health authorities for the purposes related to preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infectious exposure.

Judicial and Administrative Proceedings:
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement:
We may disclose your health information to law enforcement officials for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order of subpoena, and other law enforcement purposes.

Initials:________

Dr. Greg Chong Lee, DC

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Seattle Northeast CHIROPRACTIC

Notice of Privacy Practices 2/2

Deceased Persons:
We may disclose your health information to coroners or medical examiners.

Organ Donation:
We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

Public Safety:
It may be necessary to disclose your health information to appropriate persons in order to prevent or lesson a serious and imminent threat to the health or safety of a particular person or to the general public.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Seattle Northeast Chiropractic is not required to agree to the restriction you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request • You have the right to inspect and receive a copy of your health information.
- You have the right to request that Seattle Northeast Chiropractic amend your protected health information. Please be advised, however, that Seattle Northeast Chiropractic is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you Will be provided with an explanation of our denial • reason(s) and information about how you can disagree with the denial.
- You have the right to receive an accounting of disclosures of your protected health information made by Seattle Northeast Chiropractic.
- You have the right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Seattle Northeast Chiropractic reserves the right to amend this Notice of Privacy Practices at any time in the future and will make the new provisions effective for all the information that it maintains. Until such an amendment is made, Seattle Northeast Chiropractic is required by law to comply with this Notice. Seattle Northeast Chiropractic is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights

Complaints

Complaints about your Privacy rights, or how Seattle Northeast Chiropractic has handled your health information should be directed to Dr. Greg Chong Lee, DC or Amanda G. by calling this office at (206) 364-9501. If both are not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with in the handling of your claim by this office, you may submit a formal complaint to:
DHHS. Office of Civil Rights 200 Independence Avenue. SW Room 509F HHH Building Washington: D.C. 20201

I have read the Notice of Privacy Practices and understand my rights contained in the notice.
By way of my signature, I provide Seattle Northeast Chiropractic, PLLC with my authorization and consent to use and disclose my protected health care information for the purposes of the treatment, payment and health care operations as described in this Notice of Privacy Practices.

Patient Name: ____ Date:_________________________

Signature: ____

Staff Initials: ___________

Dr. Greg Chong Lee, DC

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Seattle Northeast CHIROPRACTIC

Auto Accident Questionnaire 1/2

Name: ____ Date: ________________

Please explain in detail how your accident happened: ____
____
____
____
____

Date of Accident: ____/____/______ Time: _________ AM PM Number of vehicles involved: _________

Location: ____

Did Police come to the scene: YES NO If yes, do you have a copy of the police report: YES NO

Were you the: DRIVER FRONT PASSENGER REAR PASSENGER (LEFT RIGHT MIDDLE)

Were you wearing a seat belt: YES NO If yes, what type: Shoulder-Lap Belt Lap Belt Only

Did the airbags deploy: YES NO Make and model of the vehicle: _______________________________

What did your vehicle impact: Another Vehicle Person Object: ____________________________

Did any part of your body strike anything in the vehicle: YES NO If yes, please describe: _______________
____

In which direction were you traveling: North East South West Speed of your vehicle: __________MPH

(IF APPLICABLE) Other driver was traveling: North East South West Speed of other vehicle: _____MPH

What area of your vehicle was the impact on: Front Rear Drivers Side Passenger Side Other: __________

During impact, were you facing: Right Left Forward Backward

Describe how you felt immediately after the accident: ____

____

Were you left unconscious: YES NO If yes, for how long: ____

Did you go to a hospital / emergency facility: YES NO If yes, where: _______________________________

Describe any treatment you received: ____

____

Were X-Rays taken: YES NO Was medication prescribed: YES NO If yes, what type: ______________

____

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Seattle Northeast CHIROPRACTIC

Auto Accident Questionnaire 2/2

Have you seen any other doctor for this accident: YES NO If yes, Doctor name and Clinic: ___________________

____

Treatment given: ____

Recommendation:____

Check symptoms you have noticed since the accident:

Headache	Dizziness	Nausea	Tingling in arms
Memory loss	Loss of balance	Fever	Loss of smell
Blurred vision	Light bothers eyes	Hands cold	Upper back pain
Buzzing in ears	Feet cold	Head seems too heavy	Leg pain
Low back pain	Numbness in toes	Loss of taste	Numbness in fingers
Jaw problems	Chest pain	Nervousness	Neck pain
Upper back stiffness	Ears ringing	Fainting	Face flushed
Neck stiffness	Shortness of breath	Arm / Shoulder pain	Wrist pain

Have you ever had any pain in the involved area(s) before: YES NO If yes, what symptoms: _________________

____

Are your work/school/daily activities restricted as a result of the accident: YES NO

If yes, what are the restrictions: ____

Since this injury, are your symptoms: Improving Getting Worse Constant Same Comes & Goes

List all major complaints and rate the intensity of the pain on a scale of 1 – 10:

Primary Complaint: ____ 1 2 3 4 5 6 7 8 9 10

Secondary Complaint: ____ 1 2 3 4 5 6 7 8 9 10

List any other complaints, concerns, or additional information: ____

____

____

I understand that the information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Printed Name: ____ Date: ________________________

Signature: ____

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Seattle Northeast CHIROPRACTIC

Financial Policies for Motor Vehicle Accidents 1/2

I understand that for the medically necessary treatment provided by Seattle Northeast Chiropractic, PLLC related to a motor vehicle accident, the primary first party insurance is with the Personal Injury Protection (PIP) Insurance for the vehicle I was driving, riding in as a passenger, or struck by as a pedestrian/bicyclist.

Personal Injury Protection (PIP) insurance is a type of automobile insurance coverage which will pay your medical necessary treatment following a car accident, regardless of fault. Claims are covered 100% if services are medically necessary due to the injury's you sustained in the motor vehicle accident. However, it is ultimately your responsibility to provide our office with the documentation necessary to prove a valid claim, as well as the names and contact information of any claim's adjuster, manager, attorney, etc. handling the case. Also, any claim numbers and mailing addresses to send medical documentation and medical claims to. Failure to provide the documentation needed will result in our office not being able to submit the required documentation to the correct correspondences, which may result in denial of care or your claim being closed.

I understand and authorize Seattle Northeast Chiropractic, PLLC to bill the applicable PIP insurance for the injuries I sustained on said date and authorize the release of any information acquired in the course of my treatment.

Date of Accident:	Driver Passenger Bicyclist Other:_______________
PIP Insurance Company:	PIP Claim #:
PIP Adjuster Name:	PIP Adjuster Phone#: EXT:

Should PIP insurance not be available, exhausted, or terminated for any reason, I authorize Seattle Northeast Chiropractic, PLLC to bill any applicable health insurance I may have available, subject to any contract Seattle Northeast Chiropractic, PLLC may have with such carrier, and authorize the release of any information acquired in the course of my examination and treatment in accordance with HIPAA privacy regulations. I understand that my health insurance may require me to complete certain forms in order to process my claims related to an automobile collision and agree to complete it in a timely manner if my insurance company requests it from me. I will be responsible for paying any applicable deductibles, coinsurance, or copays. Initials:_________

Personal Health Insurance:	Insurance ID#:

If I have no personal health insurance, my health insurance denies treatment or my health insurance is "out of network" with this practice, I authorize Seattle Northeast Chiropractic, PLLC to file a medical lien against any applicable third-party insurance (insurance of the other party involved in the accident) settlement pursuant to RCW 60.44.010, et seq. I understand and acknowledge that payment of any medical lien, in some circumstances, may not fully pay my outstanding final charges due to Seattle Northeast Chiropractic, PLLC for treatment provided, and I may be required to make additional payments after satisfaction of the lien. If liability is determined by the third-party insurance company to be the fault of I, all rendered treatment services will become my patient responsibility and due in full 30 days after last date treatment services were rendered.

Payment not made in full by 90 days may be turned over to our collection agency and a collection fee of $50 will apply, unless other payment arrangements have been approved. Initials:_________

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Seattle Northeast
CHIROPRACTIC

Financial Policies for Motor Vehicle Accidents 2/2

Third Party Insurance Company:	Third Party Claim #:
Third Party Claim Adjuster:	Third Party Claim Adjuster Phone#:

I understand that Seattle Northeast Chiropractic, PLLC will agree to await payment for services rendered until my treatment has concluded and I have settled with the third-party **provided** I have hired an attorney to assist with my claim and they have signed a **Letter of Protection** agreeing to remit payment directly to Seattle Northeast Chiropractic, PLLC out of my settlement. I further understand that my settlement may not fully pay my outstanding final charges due for treatment provided, and **I may be required to make additional payments** to Seattle Northeast Chiropractic, PLLC. Initials:_________

Law Firm / Attorney:	Firm / Attorney Contact #:

I have read this document in its entirety and fully understand the financial policies of Seattle Northeast Chiropractic, PLLC.

Letter of Protection / Direction to Pay

I do hereby authorize Seattle Northeast Chiropractic, PLLC to furnish you, my attorney, with a full report of their medically necessary examinations, diagnosis, and treatments due to the injuries I have sustained in the motor vehicle accident that occurred on _________________.

By way of my signature, I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing to them for the medically necessary services rendered to me both by reason of this accident and by reason of any other bills that are due to this office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith. I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by them for services rendered to me and that this agreement is made solely for said doctors additional protection and in consideration of them waiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. Please acknowledge this letter by signing below and returning the signed letter to the doctor's office. I have been advised that if you, my attorney, do not wish to cooperate in protecting the doctors interest, they will not await payment, but require me to make payments on a current basis.

Patient Name: ____ Date of Birth: ______________________

Signature: ____ Date: _____________________

Staff Initials: __________