Wiles Chiropractic and Massage

Gentle, Safe, and Specific
Email: DrGregoryJWiles@gmail.com
Website: DrGregoryWiles.com

University Place

2310 Mildred St. W, #100C University Place, WA 98466
Office: (253) 564-2920 Fax: (253) 564-0135

Thank you for choosing Wiles Chiropractic! We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of all our policies is important to our professional relationship. The following is a statement or our policies. We require that you read, agree to and sign prior to any treatment:

TO ALL OF OUR NEW PATIENTS

After completing the questionnaire forms, the doctor will have a consultation with you to determine whether or not you can be helped by chiropractic care…

The doctor will perform a thorough examination to determine the extent of your problem. Suggestions will then be made as to whether x-rays will be necessary and what course of therapy to follow…

On your following visit, the doctor will make further suggestions in reference to you treatment plan after he has had opportunity to review you case.

When a patient seeks chiropractic health care and we accept payment for such care, it is essential for both the doctor and patient to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the methods 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 adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of disease of 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 it maximum health potential.

We do not offer to diagnose or treat any disease or condition other then 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, diagnoses 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 the major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care of this basis.

Signature_____ Date_____

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FINANCIAL POLICY

Payment is expected at the time services are rendered. We accept cash, check, debit card, Visa, MasterCard and Discover.

If your insurance offers chiropractic coverage, we will be happy to bill your insurance directly; if we are contracted with your insurance company then we are obligated by our contract to only submit claims to them. **If we have not been successful in collecting from your insurance company after 120 days we will then bill you for the amount pending and it is your responsibility to collect from your insurance company. You** will be responsible for any amount that your insurance plan does not cover. If you have filed a claim under your personal injury protection (PIP), **you** are responsible for any outstanding balances on your account. Co-payments and /or coinsurance balances are due at the time of service unless we are contracted with your insurance company and it is otherwise stated. Insurance coverage is a contract between you and your insurance company; we file insurance claims as a courtesy to our patients. **Medicare patients –** please discuss your coverage and our policy with our office staff prior to being seen by the doctor.

Interest at the rate of 1% per month will be added to all balances over 30 days. If you have been in a motor vehicle accident and have a claim pending and /or an attorney and you have a balance that is accruing interest, you are responsible for that interest each month, you will be billed. If we are not receiving payment from an insurance company on a regular basis you will be expected to make a monthly payment toward that account that can be reimbursed to you at them of settlement. If your account goes to litigation for any reason you will be responsible for any and all attorney fees accrued. A lien will be filed on all accounts that have an outstanding balance pending settlement. Agency fees will be added to all accounts that are turned over for collections. There will be a $35 service charge for returned or N.S.F. checks.

If you are unable to make a scheduled appointment, a phone call to reschedule or cancel your appointment is required. If you so not show for and appointment and do not call to cancel your appointment, a fee of $40.00 will be charged to your account and it will be at the doctor's discretion s to whether or not he/she will continue to treat you. If you are late for your scheduled visit, we will do our best to fit you in as soon as possible. Also, in signing the statement you are giving us permission to leave phone message regarding your appointments and care with our office.

You have the right to review your personal health care records. Fees for copying your personal health information/ records are set by state regulator annually (WAC 246-08-400). The fees are a $26 clerical fee plus $1.17 per page for the 1st 30 pages and $.88 per page thereafter plus tax.

I, _____ have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in the office have been answered to my complete satisfaction. I therefore accept chiropractic care on the basis.

Signature _____ Date_____

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Name: Date:

	Main **complaint**	**How Intense? (0 - least; 10 - worst)**		**How Frequent: 100%-75%-50%-25%**					**Is it getting Worse Better Staying same**		
1.	_____	0 1 2 3 4 5 6 7 8 9 10		100%	75%	50%	25%		W	B	SS
2.	_____	0 1 2 3 4 5 6 7 8 9 10	**Circle One**	100%	75%	50%	25%	**Circle One**	W	B	SS
3.	_____	0 1 2 3 4 5 6 7 8 9 10		100%	75%	50%	25%		W	B	SS
4.	_____	0 1 2 3 4 5 6 7 8 9 10		100%	75%	50%	25%		W	B	SS

When did you first notice this/these problem(s)? _____

How does this condition interfere with normal living or working? _____

Was your condition caused by: ☐ Auto ☐ On Job Injury ☐ Other _____
Describe: _____

List any previous accidents, injuries (ex: car accidents, sports injuries) or surgeries: _____

List any major illnesses or broken bones: _____

Are you currently under any doctor's care? (Who and why): _____

Are you currently taking any medication? ☐ Yes ☐ No For what? _____

♀ Is there any possibility that you might be pregnant? ☐ Yes ☐ No
Please enter the date of the first day of your last menstrual period. (Date & Month) _____

Do you use any of the following? If so, how much and how often?

- ☐ Aspirin _____
- ☐ Ibuprofen _____
- ☐ Antacids _____
- ☐ Antihistamine _____
- ☐ Cigarettes _____ Pk/day _____ Years _____
- ☐ Coffee _____
- ☐ Alcohol ☐ Never ☐ Social ☐ Light ☐ Moderate ☐ Heavy
- ☐ Other

Health **Habits**

- ☐ Exercise Regularly
- ☐ Take Nutritional Supplements
- ☐ Consume Dairy Products
- ☐ Drink Soda Pop
- ☐ Drink Alcohol
- ☐ Recreational Drugs

Sleeping **Habits**

- ☐ Stomach Sleeper
- ☐ Back Sleeper
- ☐ Side Sleeper

Surgical **History**

Have you had any of the following?

- ☐ Tonsillectomy
- ☐ Appendectomy
- ☐ Hysterectomy
- ☐ Breast Surgery
- ☐ Bunionectomy
- ☐ _____
- ☐ _____

Additional Information:

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Birth Date: _____ / _____ / _____ Sex: ☐ Male ☐ Female Weight: _____Height:_____
Name of Parents / Guardians:_____ Phone: _____
Referred By:
_____

Purpose for contacting us?
_____
Other Doctors seen for this condition: No Yes: If yes, Doctors' names and Prior Treatments:
_____
Other Health Problems?
_____

Check any of the following conditions your child has suffered from during the past six months:

☐ Ear Infections ☐ Scoliosis ☐ Digestive Problems ☐ Bed Wetting ☐ Seizures
☐ Asthma / Allergies ☐ ADHD ☐ Car Accident ☐ Chronic Colds ☐ Recurring Fevers
☐ Temper Tantrums ☐ Colic ☐ Headaches ☐ Growing/Back Pain
☐ Other: _____

Family History:
_____

Previous Chiropractic care: ☐No ☐Yes
Chiropractor's name:_____
Date of last visit: _____ / _____ /_____ Reason: _____
Name of Pediatrician: _____
Date of last visit: _____ /_____ /_____ Reason: _____

Are you satisfied with the care your child has received there? ☐No ☐Yes
Number of doses of **Antibiotics** your child has taken:
During the past Six Months: _____ Total during his/her lifetime: _____
Number of doses of **Other Prescription Medications** your child has taken:
During the past Six Months: _____
Total during his/her lifetime: _____ List: _____

Vaccination History: ☐All ☐Some ☐None
List: _____
_____
_____

Prenatal History:
Name of Obstetrician / Midwife:
_____
Complications during pregnancy? ☐No ☐Yes List: _____

Ultrasounds during pregnancy? ☐No ☐Yes Number: _____

Medications during pregnancy/ delivery? ☐No ☐Yes List: _____

Cigarette / Alcohol use during pregnancy? ☐No ☐Yes

Location of birth: ☐Hospital ☐Birthing Center ☐Home

Birth Intervention: ☐Forceps ☐Vacuum Extraction ☐Caesarian: Emergency or Planned?

Complications during delivery? ☐No ☐Yes List: _____

Genetic Disorders or Disabilities? ☐No ☐Yes List: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____

Feeding History:

Breast Fed: ☐No ☐Yes How long: _____

Formula Fed: ☐No ☐Yes How long: _____ Type: _____

Introduced to solids at: _____ months, Cow's Milk at _____ months

Food / Juice Allergies or Intolerance: ☐No ☐Yes List: _____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference).

At what age was your child able to:

Respond to Sound: _____ Cross Crawl: _____

Respond to Visual Stimuli: _____ Stand Alone: _____

Hold Head Up: _____ Walk Alone: _____

Sit Up: _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.).

Was this the case with your child? ☐No ☐Yes

Is / has your child been involved in any high impact or contact type sports (i.e., soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? ☐No ☐Yes List: _____

_____

Has your child ever been involved in a car accident? ☐No ☐Yes List: _____

Has your child been seen on an emergency basis? ☐No ☐Yes List: _____

Other traumas not described above? ☐No ☐Yes List: _____

Prior surgery? ☐No ☐Yes List: _____

Menarche? ☐No ☐Yes Age: _____

Childhood Diseases:

Chicken Pox: ☐No ☐Yes Age: _____

Mumps: ☐No ☐Yes Age: _____

German Measles/Rubella: ☐No ☐Yes Age: _____

Measles/Rubeola: ☐No ☐Yes Age: _____

Whooping Cough: ☐No ☐Yes, Age: _____

Other: ☐No ☐Yes, Age: _____

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Thank you for choosing our office. In order to serve you properly, we will need the following information.
(PLEASE PRINT)
All information will be strictly confidential.

Patient's Name (First, MI, Last)		Birth Date	Age	Marital Status **M S**
Residence Address	City	State	Zip	Home Phone ( )
If Child, Parent Or Guardian's Name	**E-mail address** (used for newsletters, etc.)		Height	Weight
Name Of Employer	Address (with city, state and zip)			Business Phone ( )
Occupation	**Patient's Social Security Number** – –		Driver's License Number	
Nearest Friend Or Relative Not Residing With You	**Relationship To Patient**	**Address**		**Phone** **( )**
Whom May We Thank For Referring You To Our Office?	Address	Phone ( )		
Do You Have Medical Insurance? ❑ Yes ❑ No	How Do You Intend To Pay? ❑ Check ❑ Cash ❑ Credit Card	Insurance Company Name, Address & Phone Number		
Subscriber's Name	Subscriber's ID Number	Group Number	Is it through your employer? ❑ Yes ❑ No	
Name Of Spouse	Spouse's Birth Date	Spouse's Social Security Number – –		
Medicare Number				

CONSENT TO TREAT A MINOR: *I hearby authorize the doctors at* ***Wiles Chiropractic and Massage*** *and whomever they designate as assistants to administer chiropractic care to my* ❑ son ❑ daughter ❑ grandson ❑ granddaughter ❑ _____

(Name of Child) _____ **Dated at (city)** _____ **(state)** _____

(Date signed) **(Signature)** **(Witness)**

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. *I authorize request of any medical information necessary to process this claim and request payment of government benefits either to myself or to the party who accepts assignment below.*

Signed Date

Please don't forget to provide us with a copy of your insurance card.

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Consent for Purposes of Treatment, Payment & Healthcare Operations (3/0)

In this document, "**I**" and "**my**" refer to the **patient**, and

"**Chiropractor**" refers to **Gregory J. Wiles, D.C, ps**.

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. 1: understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor, I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right that Notice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted in the waiting room at 2310 Mildred St. W, #100C, University Place, WA 98466, This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the, time of my next appointment.

_____ _____

Signature of Patient or Personal Representative | Printed Name of Patient

_____ _____

Date of Signing | Description of Personal Representatives Authority

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NOTICE OF PRIVACY PRACTICES (NOPP) ACKNOWLEDGEMENT

I have read and understood the Notice of Privacy Practices policy at ***Wiles Chiropractic and Massage.***

_____ _____ _____
Printed Name Signature Date

CONTACT PREFERENCES

❒ Please contact me in any way necessary

OR

List restrictions (e.g. leave only callback number on phone messages; don't contact me at work; etc.):

_____

RECORD OF PHI DISCLOSURES

Date	Disclosure to Whom Address/Fax#	(1)	Description/Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check if disclosure is authorized
(2) Type key: T=Treatment Records, P=Payment Information, O=Healthcare Operations
(3) Enter how disclosure was made: F=Fax, P=Phone, E=E-mail, M=Mail, O=Other

WE ARE HERE TO SERVE YOU AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctors to administer care to my Son / Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Name of Insurance Company: _____

Policy #: _____

Signed: _____

Witnessed: _____ Date: _____