Bourree Chiropractic and Massage
New Patient Intake Form

Insurance Non-Covered Service Disclosure and Agreement

Name of Patient: _____

Name of provider: David Bourree D.C.DACS

Type of service:

1. **Exams**: 99201-99205: $74.00-$350.00
2. **X-Rays:** 72010-72200: $35.00-$260.00
3. **Re-Exam/ Report of findings:** 99211-99215: $35.00-$245.00
4. **Adjustments:** 98940-98942: $50.00-$90.00
5. **Extremity Adjustments:** 98943: $45.00
6. **Intersegmental Traction, Ice:** 97012, 97010: $10.00-$30.00
7. **Chiropractic Supplies,** i.e., pillows, inserts, ice packs, etc.: $3.50-$90.00
8. **Exercises and Rehabilitation:** 97110, 97530: $55.00-$60.00
9. **Massage Therapy:** 97124: $180.00
10. **Therapeutic Cold Laser Therapy:** $95.00

Proposed dates or range dates of services: See Chiropractic or Rehabilitation care schedule

Potential Reasons for Non-covered status:

- The service is or may be deemed investigational or experimental under the carrier's internal guidelines.
- The service is considered, or may be deemed, not medically necessary, unauthorized or denied pre-authorization under the carrier's internal care or cost management guidelines.
- The service is not or may not be actually covered under the plan to which the above patient is subscribed.
- The service is not or may not be deemed as not provided in accordance with the Provider's Agreement with the carrier or other requirements of the carrier's or managed entity's internal guidelines.

The carrier authorizes the provider to charge the patient for the above services so long as this disclosure is made and signed by the patient prior to the services being provided.

Patient Financial Responsibility:

The undersigned patient acknowledges that the Non-Covered status of the proposed service(s) has been explained, and that a certain portion of the patient's care may not be covered by or has not been authorized by the patient's insurance plan. The undersigned acknowledges that if any portion of the care provided is not, or may not be, covered by insurance, then the undersigned shall be responsible for payment, and shall make the necessary financial arrangements with the healthcare provider to pay for these services. We reserve the right to charge 1% on outstanding balances, per Washington State Allowable Laws.

Print Name: _____ Date: _____

Signature: _____

Insurance Plan: _____

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Terms of Acceptance

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

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment. Below are definitions that will help you have better understanding of the care that you will receive in our office.

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 or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra 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's maximum health potential.

We do not offer to treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a specialist 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 a 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.
(Print name)

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 on this basis.

Signature: _____

Date: _____

Missed Appointment Policy

Dear Patients,

All appointments are scheduled time with you and the Doctor or Massage Therapist; therefore when an appointment is missed, someone else could have had that scheduled time with the doctor.

Twenty-four hour advance notice is required for an appointment cancellation. If this notice is not given, a missed appointment fee of $45.00 will be charged directly to you for ten minute chiropractic appointments and $75.00 for extended chiropractic appointments. Our Massage cancellation fee is $95.00. **It is important to know that insurance companies do not pay for this**, and it must be paid before your next visit to this office.

Please keep your appointments.

Yours for better health,

Dr. Bourree and Staff

I have read and agreed to the above information provided.

Printed Name: _____ Date: _____

Patient Signature: _____

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Consent for purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Bourree Chiropractic and Massage for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Bourree Chiropractic and Massage.

I understand that diagnosis or treatment of me by Dr. David Bourree may be conditioned upon my consent as evidenced by my signature on this document.

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. Bourree Chiropractic and Massage is not required to agree to the restrictions that I may request. However, if Bourree Chiropractic and Massage agrees to a restriction that I request, the restriction is binding on Bourree Chiropractic and Massage and Dr. David Bourree.

I have the right to revoke this consent in writing at any time except to the extent that Dr. David Bourree or Bourree Chiropractic and Massage 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 provided, 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 understand I have a right to review Bourree Chiropractic and Massage's Notice or Privacy Practices prior to signing this document.

Bourree Chiropractic and Massage's Notice of Privacy has been provided to me.

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 Bourree Chiropractic and Massage.

This Notice of Privacy Practices for Dr. David Bourree is also provided at the front desk of Bourree Chiropractic and Massage.

The Notice of Privacy Practices also describes my right and the duties of Dr. David Bourree with respect to my protected health information.

Bourree Chiropractic and Massage 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 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 or Personal Representative: _____

Date: _____ Description of Personal Representatives Authority: _____

With whom may we discuss your healthcare and appointments? _____

Is it okay if we leave a voicemail message for you at the phone numbers provided? (Please circle) YES NO

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Authorization for Taking and retaining X-Ray Films

Date: _____

I hereby authorize the taking of analytical x-ray films by the above doctor/clinic, and/or staff of such areas as may be of anatomical interest and which may be recommended from time to time by the above doctor or doctors.

Further, I agree that the above doctor/clinic shall be the sole owner of such analytical films and shall remain in custody and in control of said films, until such a time as I shall sign a Release Form stating otherwise: such form to be provided by the above upon request.

Print Name: _____

Signature: _____

Parent or Guardian (if applicable): _____

Witness Name: _____

Witness Signature: _____

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/ her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual cycle: _____

Signature: _____

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Assignment of Insurance Benefits

I authorize Bourree Chiropractic and Massage to bill: _____ Insurance company, and to pay by check made out directly to: **Bourree Services, P.S.**

This is a direct assignment of my benefits and right under this policy. This payment will not exceed my indebtedness to the assignee and I have agreed to concurrently pay any balance of said services which may exceed this insurance payment.

Signature of policy holder: _____

Signature of claimant, if not policy holder: _____

There is a possibility that insurance may not cover your services in this office. This may be because your insurance may deem the service not medically necessary, or may not be covered under your insurance plan, or the appropriate referral may not be in place.

The carrier authorizes the provider to charge the patient for the services so long as this disclosure is made and signed by the patient prior to the services being provided.

The undersigned patient acknowledges that the non-covered status of the proposed services has been explained, and that the patient's care may not be covered by or has not been authorized by the patient's insurance plan. The undersigned acknowledges that if any portion of the care provided is no, or may not be covered by insurance, then the undersigned shall be responsible for payment, and shall make the necessary financial arrangements with the healthcare provider to pay these services. I understand that Bourree Chiropractic and Massage may charge a 1% interest on outstanding balances.

Print Name: _____

Signature: _____

Insurance Plan: _____ Date: _____

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Release of Records

Date: _____

To: _____

I, _____, hereby request the above- named to release copies or all pertinent medical records and records and x-ray films to Bourree Chiropractic and Massage, David Bourree, DC DACS as of the above date. These records may be sent directly to the doctor/clinic, or given to me personally.

Printed Name: _____

Signed: _____
(Patient and/or Patient's Representative)

Date of Signature: _____

Records to be sent to:
David Bourree DC, DCAS
12841 NE 85th ST
Kirkland, WA 98033
ATTN: David Bourree

Original records and x-ray films will be returned when they have served their purpose. Thank you for your cooperation.