Joseph L. Dumovic, D.C., N.D., Inc., P.S.

Mailing: PO BOX 177 Hobart, WA 98025

Phone (206)244-5216 - Fax: (206) 244-0897

NON-COVERED SERVICES MEMBER CONSENT FORM I,

_____ (list patient name and member number), understand that the services and/or supplies listed below may not be considered eligible for benefits (e.g., services and/or supplies may be determined to be not medically necessary, non-covered or investigational) by _____ _____ (health insurer). I understand that my health insurance coverage has certain restrictions and limitations, such as authorization requirements, and non-covered services and/or supplies. Since I have chosen to obtain the services and/or supplies listed below, I agree to be financially responsible for any and all related charges, if they are not covered by my insurance.

ULTRASOUND $30.00, E-STIM $40.00 , LASER $40.00 , HOT PACKS $20.00, B12 $35.00, Procaine $60.00

Services/Supplies

_____

Condition/Diagnosis

_____

Date of Service

X _____

Member or Legal Guardian Signature **Member Identification Number Date**

Any Changes in insurance, address, phone number must be communicated to the front desk as soon as possible. Co-pay is due at the time of check-in. It is the patient's responsibility to be aware of insurance benefits, coverage, and authorization required for services.

As a reminder: Our office has the right to charge a $35.00 missed appointment fee for any appointments missed or canceled less than 24 hours of the scheduled appointment.

New statement fees: There will be a $1.00 statement fee applied to every statement printed and mailed. Due to HIPAA regulations we are not able to email statements.

Making payments: Credit Card Payments call 206-244-5216 (mon-thur 9am-5pm pst). Check payments are accepted by mail. Cash, check, credit card payments accepted in person at the office.

New late payment charge: Payments are due 20 days from the statement date. Any payments received after the 20 days will be subjected to a finance charge of 10% APR.

Please sign on the line below showing your understanding of the information listed above. Any questions can be directed to any front office staff member.

X _____ X _____

Printed Name Signed Name Date

_____

Witness Signature Date

PATIENT REGISTRATION

DATE:_____

LEGAL NAME:_____ Male ☐ Female☐
First Middle Last

Title:_____ Single_____ Married_____ Widowed____ Divorced_____ Separated____

SSN#:_____ Date of Birth:_____ Age:_____

ADDRESS:_____ APT#:_____

CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:_____ CELL PHONE:_____

WORK PHONE:_____ E-MAIL:_____

EMPLOYER:_____ Position:_____

Occupation:_____ Full/Part Time:_____ Retired?: Yes ☐ No☐

Business Address:_____

SPOUSE/PARTNER NAME:_____ Employer:_____

Occupation:_____ Business Phone:_____

EMERGENCY CONTACT (other than spouse):_____ Relationship:_____

Address:_____ Phone:_____

PERSON RESPONSIBLE FOR ACCOUNT (If other than patient):_____

Relationship:_____ SSN:_____ Phone:_____

Address:_____

PRIMARY INSURANCE COMPANY:_____

Group#:_____ Policy or Claim#:_____

Subscriber:_____ Subscriber's SSN#:_____

Subscriber's Date of Birth:_____ Relationship to Patient:_____

IF INJURED: Date:_____ ☐ Injured at Work? Cause:_____

REFFERED TO THIS OFFICE BY:_____

Joseph L. Dumovic, D.C., N.D., Inc., P.S.
PO Box 177, Hobart, WA 98025 Phone (206)244-5216 Fax: (206)244-0897

FINANCIAL POLICY

PAYMENT:

1. Payment for all visits, supplements, and labs is expected at the time of service, unless some other pre-approved payment arrangement is made with the office.
2. Cash, check and Mastercard/Visa/Discover are accepted forms of payment
3. If a payment cannot be made on the day of service, post-dated checks are acceptable.

INSURANCE:

4. Some insurance policies offer full or partial coverage for Chiropractic or Naturopathic care. Our billing department will submit the appropriate billing forms, if Dr. Dumovic is a provider for your insurance company. However it is your responsibility as the patient to verify with your insurance carrier if your particular plan has coverage for the care you are receiving.
5. Some insurance plans require a referral from your PCP (Primary Care Physician) in order for the treatment to be covered by your insurance company. It is your responsibility to know if your insurance plan requires one, and to obtain it from you PCP prior to your appointment with this office. In the event that no referral is in place, you are still responsible for any non-covered expenses.

ON-THE-JOB INJURIES:

6. Workman's Compensation does provide for Chiropractic & Naturopathic care. On-the-job injuries are billed by the office to the State and private L&I agencies. Payment for denied claims is the responsibility of the patient.

PERSONAL INJURIES/AUTO ACCIDENTS:

7. Auto accidents or personal injury cases are billed by this clinic with verification of your insurance company or attorney. It the patient's responsibility to obtain policy and claim numbers for the Personal Injury Protection (PIP), insurance coverage, the adjuster's name, and the billing address. It is also the patient's responsibility to obtain an attorney to help in the settlement of all medical fees, emotional trauma, attorney fees, and any time loss incurred.

GENERAL POLICY FOR ALL OF THE ABOVE:

8. There is a $36.00 charge for all returned checks.
9. We request a minimum of 24 hours notice for appointment changes and cancellations. Not giving adequate notice of cancellation or missing an appointment will result in a minimum $35.00 charge. We reserve the right to charge up to the full amount of the missed appointment. Please note: If you are 15 minutes late for a chiropractic appointment or 30 minutes late for a Naturopathic appointment you have missed your appointment and will need to reschedule.

◆◆◆◆◆◆◆◆◆◆

I have read and understand this Financial Policy. I hereby authorize Dr. Dumovic to perform diagnostic tests deemed necessary for my care, and to perform any and all forms of treatment, medication, and therapy that are indicated, and that I am in agreement with, which are in accordance with the Standards of Naturopathic/Chiropractic medicine. I hereby authorize the doctor to release any information required by my insurance company to expedite payment of claims submitted. I also authorize my insurance benefits to be paid directly to Dr. Dumovic, and understand that I am financially responsible for any services not covered by my insurance carrier. I agree to pay any outstanding balance in a timely manner.

PRINT NAME: _____ **SIGNATURE:** _____

WITNESSED BY: _____ **DATE:** _____

Joseph L. Dumovic D.C., N.D., Inc., P.S.
P.O. Box 177 Hobart, WA 98025: PH 425-432-6039, Fax: 206-244-0897

Informed Consent for Treatment

I hereby request and consent to the performance of naturopathic and/or chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic and naturopathic named below and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic/naturopathic treatments. Those complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homer's syndrome, diapragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, that are in my best interest.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of treatment. I state that I have been informed and weighed the risks involved in naturopathic and chiropractic treatment at this health care office. I have decided that it is in my best interest to receive treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

_____

Printed name of Patient

_____ _____

Signature of Patient Date

_____ _____

Signature of Guardian/Parent Date

(If patient is under 18 years old, or is physically or mentally unable to sign – this signature indicates guardian consent for the Doctor to treat the patient.)

_____ _____

Witness to Patients Signature Date

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STATEMENT OF PRIVACY PRACTICES

Joseph L. Dumovic D.C., N.D.
P.O. Box 177
Hobart, WA 98025
206-244-5216

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given to anyone – even family members – without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of your Protected Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards.

Patient Rights

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

Dumovic Clinic initials x _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Dr. Joseph L. Dumovic. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and the duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Dr. Joseph L. Dumovic reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that it be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY	
In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.	
Any member of my immediate family	☐Yes ☐No
Spouse only	☐Yes ☐No
Other (please specify)	☐Yes ☐No

Patient Name (Please Print)

Signature (of Patient or Personal Representative)

Description of Personal Representative's Authority

Date

OFFICE USE ONLY BELOW THIS POINT

RECORD OF ACKNOWLEDGEMENT	
Provided Prior to Treatment?	☐Yes ☐No
Date Provided:	
If not provided, reason for denial:	
☐ Needed more time to review statement of privacy practices.	
☐ Wanted to consult with another person before signing.	
☐ Unable to sign.	
☐ Reason not given.	
☐ Other (explain):	

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PATIENT HISTORY

NAME:_____ **Age:**____ **Date**_____

List your health problems in order of importance.

1. _____
2. _____
3. _____
4. _____

PERSONAL HISTORY: (Please check the relevant areas and give some detail below)

___Alcoholism
___Allergies
___Anemia
___Arthritis
___Asthma
___Cancer
___Colitis
___Diabetes
___Drug Addiction
___Gastrointestinal disorders
___Headaches
___Heart disorders
___Herpes genitalis
___High blood pressure
___Hypoglycemia
___Injury (serious)
___Liver disorders
___Psychological disorders
___Seizures
___Skin disorders
___Stroke
___Thyroid disorders
___Tuberculosis
___Venereal disease

Other and/or details

_____

_____

_____

NAME OF CURRENT OR MOST RECENT FAMILY PHYSICIAN:

_____

CURRENT PHYSICAL EXAM (within last year): ☐ **YES DATE**_____ ☐ NO

PREVIOUS HOSPITALIZATIONS/MAJOR ILLNESSES: – give dates and types of illness/operation

_____

_____

KNOWN ALLERGIES: (Foods, airborne, chemicals, or medications)_____

_____

MEDICATIONS & SUPPLEMENTS:_____
(Include prescription and non-prescription items, herbs, vitamins etc.)

_____

WEIGHT:
Present _____lbs **Usual** _____lbs **Wt change over last year: gained** _____lbs **lost** _____lbs

DIET AND HEALTH HABITS

List foods excluded from diet. _____
Satisfied with your diet as it is now? ☐ **Yes** ☐ **No Comments:** _____

Drug use? ☐ **Yes** ☐ **No If yes, how many years?**_____ **Type?**_____
Drink Alcohol? ☐ **Yes** ☐ **No If yes, amount per week?** _____
Drink coffee or soft drinks? ☐ **Yes** ☐ **No If yes, amount daily?** _____
Smoke cigarettes or use other tobacco products? ☐ **Yes** ☐ **No Daily amount?** _____
How many glasses of water do you drink per day?_____ **Are you constipated?** ☐ Yes ☐ No

Do You exercise regularly? ☐ **Yes** ☐ **No**
If yes, type and frequency?_____

FAMIILY HISTORY:

Family History	Age if Living	Age at Death
Father		
Mother		
Brothers: Number_____		
Sisters: Number _____		
Children: Boys _____		
Girls _____		

IMUNIZATIONS & DATES			
MMR			
Polio			
Pertussis			
Tetanus			
Hepatitis B			

(Write Yes, No, or DK (don't know), for blood relatives):

___Alcoholism
___Allergies
___Anemia
___Arthritis
___Asthma
___Cancer
___Colitis
___Diabetes
___Drug Addiction
___Gastrointesinal disorders
___Gout
___Hay fever
___Heart disorders
___High blood pressure
___Hypoglycemia
___Liver disorders
___Mental illness
___Migraine
___Seizures
___Skin disorders
___Stroke
___Thyroid disorders
___Tuberculosis
___Venereal disease

Other significant family health problems? _____

_____

DO YOU HAVE A LIVING WILL? (This could include, but is not limited too, an Advance Medical Directive, Durable Power of Attorney, or Health Care Proxy.) ☐ **Yes** ☐ **No** If yes, and Dr. Dumovic is your Primary Care Physician, we are required by law to have a copy on file.

OTHER COMMENTS- Any additional information you feel would be helpful for Dr. Dumovic to know.

_____

_____

****

FEMALES ONLY: Please Complete

Menstrual cycles : Regular? ☐ **Yes** ☐ **No** **Length of cycle?** _____

Hysterectomy? ☐ **No** ☐ **Yes Total?** _____ **Partial?** _____

Number of Pregnancies?_____ **Births?** _____ **Miscarriages?** _____ **Abortions?** _____

History of Breast lumps? ☐ **Yes** ☐ **No** **Do you use birth control pills?** ☐**Yes** ☐ **No**

Check if you have had: _____**D & C** _____**Toxemia** ____ **Cesarean Section**
_____**Difficulty with pregnancy** _____ **with Labor** _____ **with Delivery**

Date of last Pap? _____ **Date of last Mammogram?** _____