

# Atlas Spinal Care, P.C.

16500 SE 15th Street  
Suite 160  
Vancouver, WA 98683

(360) 718 - 7944  
Fax: (360) 718 - 7931

## Financial Policy

### Missed Appointments

- Appointments not rescheduled with 24-hour notice will be subject to a \$25 fee.

### Self-Payment

- If you are a self-paying patient, payment is expected at the time of service.
- A time of service discount is offered to all chiropractic patients if payment is received on the same day of service; if not, regular fees will be applied.

### Health Insurance

- If insurance coverage is verified, we will bill for services, but co-payment is expected at the time of service. You are responsible for any unpaid balance by your insurance company.

### Workers Compensation Claims

- All worker's compensation cases will be billed directly to the insurance company, provided the appropriate paperwork has been filled out and a claim has been filed. If the claim is denied, we will bill your private insurance carrier if you have coverage. Please keep in mind that if your claim is denied, you are responsible for prompt payment of your account.

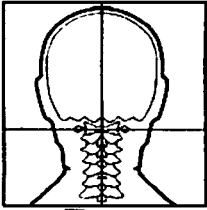
### Personal Injury/Motor Vehicle Accidents

- Personal injury and auto accident cases will be billed to your insurance company, providing that a claim has been filed and the appropriate paperwork has been done.
- If you choose not to file a claim with your auto insurance company, or are uninsured, your account will be treated as a cash account, and all fees will be due at the time of service.

*I have read and understand the above financial policy:*

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_





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# 1

## PATIENT INFORMATION

Name: \_\_\_\_\_  
(First) (Initial) (Last) (Name called by)  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Birthday: \_\_\_\_\_ Age: \_\_\_\_  Male  Female  
Social Security # \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Occupation: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Parents Name(if a minor): \_\_\_\_\_  
 Single  Married  Divorced  Widowed  Separated  
Spouse/Partner's Name: \_\_\_\_\_  
# of Children: \_\_ Name(s) \_\_\_\_\_

# 2

## INSURANCE

Who is responsible for this account? \_\_\_\_\_  
Relationship to patient \_\_\_\_\_  
Insurance company \_\_\_\_\_  
Insurance ID number \_\_\_\_\_  
Group / Claim number \_\_\_\_\_  
Is patient covered by additional insurance?  Yes  No  
Insurance company \_\_\_\_\_  
Subscriber # and name \_\_\_\_\_  
Birthdate \_\_\_\_\_ Group # \_\_\_\_\_  
Please present insurance card(s) so we can put a copy in your file.

# 3

## ACCIDENT INFORMATION

Is your condition due to an accident?  No  Yes Date: \_\_\_\_  
Type of accident?  Automobile  Work  Home  Other  
To whom have you reported the accident?  
Insurance  Worker's Comp  Employer  Other \_\_\_\_  
Attorney Name (If applicable) \_\_\_\_\_

# 4

## CONTACT INFORMATION

Home phone \_\_\_\_\_  
Cell phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Ext \_\_\_\_\_  
Email \_\_\_\_\_  
Best way to reach you  Home  Cell  Work  Email  
IN CASE OF EMERGENCY, CONTACT  
Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

# 5

## PATIENT CONDITION

What is your major symptom/problem? \_\_\_\_\_  
When did your symptoms begin? \_\_\_\_\_  
Have you had this problem before? \_\_\_\_\_  
Is your condition getting progressively worse? Yes  No   
Is this problem:  constant  comes and goes  
How does it Feel?  Burning  Sharp  Shooting  Dull  Aching  Stiff  
 Tingling  Throbbing  Swelling  Other \_\_\_\_\_  
Circle below the severity of your pain on a scale of 0 to 10:  
(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe pain)  
What makes your condition better? \_\_\_\_\_  
What makes your condition worse? \_\_\_\_\_  
Does it interfere with your  Work  Sleep  Daily Routine  Recreation  
Activities/movements that are painful to perform:  
 Sitting  Standing  Walking  Bending  Lying down  Driving  Reading

Please Mark Where it Hurts

