



Auto Financial No-Show/Cancellation Policy

To better serve our patients and assure that they have a fair opportunity to have an appointment as promptly as possible, please observe our cancellation policy for chiropractic, massage, and acupuncture appointments.

We require a minimum 24-hour notice to cancel or reschedule massage, acupuncture, and new patient chiropractic appointments. We also require at least 2 hours notice for follow up chiropractic appointments.

Authorization for Credit Card Use

(All information will be kept confidential)

Cardholder Name: _____

Billing Address: _____

Card Number: _____

Expiration Date (mm/yy): _____

CCV: _____

I, _____ authorize Washington Park Chiropractic to charge my card for any late cancellations or missed appointments.

Signature

Date

Fees

Chiropractic: no-shows/late cancels will be billed \$25 for the first missed appointment and full price for subsequent missed appointments.

Massage, Acupuncture & Nutrition: no-shows/late cancels will be billed for half of the price of the appointment for the first miss and full price for any subsequent missed appointments.

Please arrive on time for your appointment. If you know you will be late, please call to verify that the doctor will be able to devote your full scheduled time to you. If it is best, we will reschedule your appointment.

Parent/Guardian Signature

Date

Parent/Guardian Name (print)



Informed Consent

I, the undersigned, have voluntarily requested that the Doctors and/or other providers at Washington Park Chiropractic assist me in the management of my health concerns. I understand and agree to all policies and terms provided in the Office Policies and Procedures.

Meet the Doctors

Dr. Lisa Goodman, DC, CCSP, CACCP
2006 Graduate of Palmer College of Chiropractic West, San Jose, CA
Certified Chiropractic Sports Physician
Certified by the Academy Council of Chiropractic Pediatrics
Webster, Prenatal Certified
Graston Certified (Instrument Assisted Soft Tissue Mobilization)
Functional and Kinetic Treatment with Rehab (FAKTR)

Dr. Chad London, DC, CCSP
2012 Graduate of Palmer College of Chiropractic, Davenport, IA
Webster, Prenatal Certified
Certified Chiropractic Sports Physician
Functional and Kinetic Treatment with Rehab (FAKTR)

Dr. Katherine Mullen, DC, MS
2019 Graduate of University of Western States, Portland, OR
Masters of Sports Medicine
Pre-Participation Physical Examination Certified

Chiropractic

Chiropractic healthcare is primarily concerned with the relationship between structure (primarily of the spine) and function (primarily of the nervous system). The Doctor of Chiropractic evaluates the patient using standard examination and testing procedures, such as orthopedic and neurologic evaluation and possibly x-rays, along with specialized chiropractic evaluation including observation, inspection, auscultation and palpation. The chiropractic examination focuses on structural or functional abnormalities called segmental dysfunction. Segmental dysfunction exists when one or more vertebrae in the spine or bones in the extremities are fixated sufficiently to result in damage or irritation to either nearby nerves, joints, and/or tissues such as muscles and ligaments. The primary goal of chiropractic treatment is to remove the segmental dysfunction. This is accomplished by performing a procedure unique to chiropractic called an adjustment. An adjustment involves the application of a quick, precise force directed over a very short distance to a specific vertebrae or bone. Adjustments are usually performed by hand, but may use a hand-guided instrument. In addition to adjustments, other treatments used by chiropractors include physiotherapy modalities (ice, heat, soft tissue manipulation), nutritional recommendations and rehabilitative procedures.

As is the case with all health care interventions, the benefits of care must be weighed against the inherent risks and limitations of receiving treatment. Chiropractic treatments are one of the safest interventions available to the public as evidenced by malpractice statistics. While there are risks involved with treatment, these are seldom great enough to contraindicate care.

Manual Therapy

A large part of our treatment involves manual therapy performed by hand or by using instruments. Manual Therapy is generally performed to increase range of motion, reduce scar tissue and treat sprains and strains. Some common side effects of Manual Therapy include soreness and bruising.

K-Laser Therapy

Laser therapy is a safe and effective therapy that is FDA cleared for the temporary relief of pain and reduction of symptoms associated with mild arthritis and muscle pain. Laser also promotes relaxation of muscle spasms and promotes vasodilation. Adverse effects from laser therapy are normally rare and temporary.

Pain relief from laser therapy may be dramatic and substantial, lasting for hours, days or weeks. However, your results may be minimal or insignificant. Adverse effects of laser therapy may occur from multiple causes including hypersensitivity, preexisting health conditions, thermal effects, excessive pressure from the probe, and laser over-stimulation. Laser light can damage the retina in your eye. Always wear the laser protective glasses provided.

Most common side effects are:

1. Temporary increase in pain during application of laser.
2. Temporary increase in pain the following day after laser therapy.
3. Mild bruising from vasodilation or direct pressure of laser tip.
4. Temporary dizziness.
5. Reactions when photosensitizing drugs are used with laser therapy.

Stretching

The use of gentle force to stretch muscles, which may alleviate sore muscles and increase range of motion. This involves the provider moving joints through their full range of motion and holding the position for an amount of time. The provider may ask the patient to meet their full resistance to activate muscles, which is called PNF (Proprioceptive Neuromuscular Facilitation).

Results from Treatment

I understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasms. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine as well as chiropractic is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

Possible Risks & Side Effects from Treatment

One research study indicated that within the first 2 months of care, approximately half of patients report some "reaction" to chiropractic treatment. Of those who reported a reaction, the following were the most commonly reported reactions to initial chiropractic treatment:

- Local Discomfort (53%)
 - Headache (12%)
 - Tiredness (11%)
 - Radiating Discomfort (10%)
- Most appeared within 4 hours of treatment and resolved within 24 hours.

Rare, yet possible side-effects / Complications

- Rib Fracture
- Disc Herniation
- Cauda Equina Syndrome (1 case per 100 million adjustments)
- Compromise of the vertebrobasilar artery (ie. Stroke) (1 case per 400,000 to 1 million cervical spine adjustments)

Stretching & Exercise Disclaimer

Additional risks are present with stretching and exercise. These risks are increased if you have had surgery or have had a surgical implant or device or history of dislocation. Please consult your treating and/or operating physician prior to engaging in any stretching or exercise program.

Alternative Treatments Available

Reasonable alternatives to these procedures have been explained to me including:

Medications: I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, create undesirable side-effects, produce physical or psychological

dependence, and may have to be continued indefinitely. Some medications may involve serious risks that I should discuss with my medical doctor.

Rest/Exercise: Simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for conditions such as joint instability or serious disk rupture, among others. Surgical risks may include unsuccessful outcomes, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

PLEASE CIRCLE the answer to all questions below to help us determine possible risk factors:

1. Have you ever had an adverse (ie. bad) reaction to or following chiropractic care? Y N
2. Have you ever been diagnosed with osteoporosis or osteopenia? Y N
3. Do you take corticosteroids (ie. Prednisone)? Y N
4. Have you ever been diagnosed with a fracture of the spine? Y N
5. Have you ever been diagnosed with cancer? Y N
6. Do you take Warfarin (coumadin), heparin or other "blood thinners?" Y N
7. Have you ever had a stroke or TIA (transient ischemic attack)? Y N
8. Have you ever been diagnosed with any of the following?
 - a. Rheumatoid Arthritis Y N
 - b. Reiter's Syndrome, Ankylosing Spondylitis, Psoriatic Arthritis Y N
 - c. Ligamentous Hypermobility (Marfans, Ehlers, Danlos) Y N
9. Have you ever become dizzy while turning your head? Y N
10. Have you ever had spinal / back surgery? Y N
11. Have you ever been diagnosed with spinal stenosis? Y N
12. Have you ever had any of the following problems?
 - a. Sudden weakness in the arms of legs? Y N
 - b. Numbness in the genital area? Y N
 - c. Recent inability to urinate or lack of control when urinating? Y N
13. Are you currently pregnant or potentially pregnant? Y N
14. Have significant bruising throughout the body? Y N
15. Undergoing chemotherapy? Y N

A thorough health history and physical examination will be performed on me to minimize the risk of any complications from treatment and I freely assume these risks.

I have read or have had read to me the above explanation of chiropractic treatment. The doctor has also asked me if I want a more detailed explanation; but I am satisfied with the explanation and do not want any further information. I have made my decision voluntarily and freely. To attest to my consent to these examination and treatment procedures, I hereby affix my signature to this Informed Consent document.

Signature of patient (or guardian) _____ Date _____

Doctor's Signature _____ Date _____

I explained the procedures, alternatives, and risks in conference with the patient.



HIPAA Privacy Practices – Patient Reception Form

I have received or reviewed the privacy practice notice for Washington Park Chiropractic, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially initiated care at this office on my first visit, whenever that may have occurred.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

Patient/Guardian Signature

Date

Print Patient Name

Exception and Records Release

I allow the doctors and staff at Washington Park Chiropractic to discuss my treatment and diagnosis with the following doctors, health care professionals, coaches, lawyers, spouses, etc.

Name

Title

Patient/Guardian Signature

Date

Print Patient Name

WASHINGTON PARK CHIROPRACTIC



Automobile Accident History Form

Patient Name: _____ DOB: _____ Date: _____

Accident Information

Date of Accident _____ Time of Accident _____

State/City of Accident _____ Street of Accident _____

Road conditions at the time of accident Wet Dry Icy Other _____

Did the Police come to the scene? Yes No Is there an accident report? Yes No

Were you working or in a work vehicle during the accident? Yes No If yes, have you notified your employer? Yes No

Treatment Information

Did you go to the Hospital? Yes No If Yes, name and city of hospital _____

Did you go via ambulance? Yes No Did you have X-rays? Yes No

If Yes, what body parts were X-rayed _____

What treatment did you receive at the hospital? _____

How long did you stay at the hospital? _____

Have you been treated by any other health care professional regarding the accident? Medical Doctor Dentist Massage

Acupuncture Chiropractic Other

Name of provider(s) and facility: _____

Injury Information

Did you break any bones? Yes No Did you have any cuts or bleeding? Yes No

Did you lose Consciousness? Yes No Did you have any bruises? Yes No

Did you become Dizzy Confused Nauseated Disoriented Lightheaded

Did you have Blurred vision/ Ringing in ears? Yes No

Accident Mechanism

Were you the Driver Passenger Did you see the accident coming? Yes No

Were you wearing a seat belt? Yes No

Were you Rear-ended T-boned Side-swiped Front-ended Other _____

How far is the headrest from the back of your head? _____ inches

Was your head pointing straight forward at impact? Yes No If no, what direction was it facing _____

Was the car stopped at impact? Yes No If yes, was the driver's foot on the brake? Yes No

If no, estimate the speed your car was going at impact _____ mph

Were you speeding up slowing down moving at a constant speed?

List the Year _____ Make _____ Model _____ of the vehicle you were in.

What is the estimated damage to the vehicle \$ _____

The Other Vehicle Information

Estimate the speed of the other car involved in the accident _____ mph

Were they speeding up slowing down moving at a constant speed

List the Year _____ Make _____ Model _____ of the other vehicle involved in the accident.

Your Account of the Accident

Were you at fault? Yes No

If yes, did you brace yourself for it? Yes No If yes, was it a Lap belt or Shoulder harness? _____

WASHINGTON PARK
CHIROPRACTIC



Please describe your account of the accident:

List symptoms that you noticed immediately after accident:

List symptoms that you have noticed since the accident:

Auto Accident Office Policy

Our office policy and recommendation is as follows:

1. Medical Payments Coverage on your Auto Insurance

Often called “*med-pay*” for short, Medical Payments Coverage is a type of insurance which provides at least \$5,000 coverage for the insured driver and passengers to pay for injuries sustained in a car accident, **regardless of who is at fault**. Although the coverage is mandatory, there is a provision for consumers who do not want med-pay coverage to opt-out in writing.

If you have Med Pay, our office policy is to submit your bills and treatment notes to *your* insurance company if you are making a claim. If the other party has taken responsibility we will still send all claims to your insurance company and they can recover costs independently.

Source: Colorado Department of Regulatory Agencies. <http://www.dora.state.co.us/insurance/consumer/Med-Pay%202009.html>

2. No Medical Payments Coverage on your Auto Insurance If you don't have Medical Payments Coverage or have opted-out your other options are as follows:

a. **Health Insurance** We are happy to verify your health insurance to determine if you have coverage in our office. We are an out-of-network provider which means you may have a deductible to meet before your benefits begin. Once your insurance has been verified we will handle all billing and collections from your health insurance carrier.

b. **Pay at the Time-Of-Service** Many patients chose to benefit from our time-of-service discount by paying for treatment as they go. Our office will not bill your claims to any insurance company and you will be responsible for payment. However, you are eligible to send in receipts and possible be reimbursed from the At-Fault Auto Insurance company if they deem your treatment ‘medically necessary’

c. **Lien** A Lien is a loan provided by the health care provider, in this case by our office. A Lien is offered when a patient is unable to afford the necessary treatment after an auto accident. In this case the health care provider will not be reimbursed until after the case settles. Because there is risk involved with offering a Lien, our office policy is to require that an attorney handle your case and work with our office.

Please contact our office with any further questions or if you need help determining which of the above payment methods will be best for you.

Please Note: *if you do not have Med Pay on your auto insurance or we have not verified it prior to your first appointment, all payments for your first visit will be due at the time of service.*

Parent/ Guardian Initial

Automobile Accident Financial Summary Form

Patient Name: _____ DOB: _____ Date: _____

Date of Accident: _____

1. Have you made a vehicle claim? Yes No Estimated Damage to your Vehicle \$ _____

2. Have you made a medical or injury claim? Yes No If yes, which insurance company Mine The other person's

3. Were you at fault? Yes No

4. Do you have an attorney? Yes No

Attorney _____ Phone _____
Email _____

5. Do you have Medical Payments Coverage on your Auto Insurance: Yes No

6. Have you received a coverage confirmation letter from your insurance? Yes No If so, *please bring us a copy.*

Your Insurance Company _____
 Agent/Adjuster Name: _____ Phone Number: _____
 Policy Number _____ Claim Number _____

Medical Payments Coverage (MedPay) Summary

Our office policy is to submit your bills and treatment notes to your insurance company if you are making a claim. If you are not making a claim, you will be considered a Self-Pay patient and payment will be due at the time of service. If the other party has taken responsibility we will still send all claims to your insurance company and they can recover costs independently. Often called “med-pay” for short, Medical Payment Coverage is a type of insurance which provides at least \$5,000 coverage for the insured driver and passengers to pay for injuries sustained in a car accident, regardless of who is at fault. Although the coverage is mandatory, there is a provision for consumers who do not want med-pay coverage to opt-out in writing.

Source: Colorado Department of Regulatory Agencies. <http://www.dora.state.co.us/insurance/consumer/Med-Pay%202009.html>

Parent/Guardian Signature

Date

LOW BACK AND DISABILITY INDEX

Full Name: _____

Date: _____

This questionnaire has been designed to give us information as to how your low back pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the one box that applies to you. We realise you may consider that two or more statements in any one section relate to you, but please just mark the box that most closely describes your problem.

Section 1: Pain Intensity

- I can tolerate the pain I have without having to use
- I can stand as long as I want without extra pain killers
- I can stand as long as I want but it gives me extra pain
- The pain is bad but I manage without taking pain
- Pain prevents me from standing for more than one hour killers
- Pain prevents me from standing for more than 30 minutes
- Pain killers give complete relief from pain
- Pain prevents me from standing for more than 10 minutes
- Pain killers give moderate relief from pain
- Pain prevents me from standing at all
- Pain killers give very little relief from pain
- Pain killers have no effect on the pain and I do not use them

Section 2: Personal Care (Washing, Dressing, etc.)

- I can look after myself normally without causing extra pain
- I can look after myself normally but it causes extra pain
- It is painful to look after myself and I am slow and careful
- I need some help but manage most of my personal care
- I need help every day in most aspects of self care
- I don't get dressed, I was with difficulty and stay in bed

Section 3: Lifting

- I can lift heavy weights without extra pain
- I can lift heavy weights but it gives extra pain
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, i.e. on a table
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- I can lift very light weights
- I cannot lift or carry anything at all

Section 4: Walking

- Pain does not prevent me walking any distance
- Pain prevents me walking more than one mile
- Pain prevents me walking more than 1/2 mile
- Pain prevents me walking more than 1/4 mile
- I can only walk using a stick or crutches
- I am in bed most of the time and have to crawl to the toilet

Section 5: Sitting

- I can sit in any chair as long as I like
- I can only sit in my favorite chair as long as I like
- Pain prevents me from sitting more than one hour
- Pain prevents me from sitting more than 1/2 hour
- Pain prevents me from sitting more than 10 minutes
- Pain prevents me from sitting at all

Section 6: Standing

- I can stand as long as I want to without extra pain
- I can stand as long as I want but it gives me extra pain
- Pain prevents me from standing for more than 1 hour
- Pain prevents me from standing for more than 30 minutes.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

Section 7: Sleeping

- Pain does not prevent me from sleeping well
- I can sleep well only by using medication
- Even when I take medication, I have less than 6 hrs sleep
- Even when I take medication, I have less than 4 hrs sleep
- Even when I take medication, I have less than 2 hrs sleep
- Pain prevents me from sleeping at all

Section 8: Traveling

- I can travel anywhere without extra pain
- I can travel anywhere but it gives me extra pain
- Pain is bad, but I manage journeys over 2 hours
- Pain restricts me to journeys of less than 1 hour
- Pain restricts me to short necessary journeys under 30 minutes
- Pain prevents me from traveling except to the doctor or hospital

Section 9: Social Life

- My social life is normal and gives me no extra pain
- My social life is normal but increases the degree of pain
- Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. dancing, etc.
- Pain has restricted my social life and I do not go out as often
- Pain has restricted my social life to my home
- I have no social life because of pain

Section 10: Employment/Homemaking

- My normal homemaking/ job activities do not cause pain.
- My normal homemaking/ job activities increase my pain, but
- I can still perform all that is required of me.
- I can perform most of my homemaking/ job duties, but pain
- prevents me from performing more physically stressful activities (e.g. lifting, vacuuming)
- Pain prevents me from doing anything but light duties.
- Pain prevents me from doing even light duties.
- Pain prevents me from performing any job or homemaking chores.

LOW BACK PAIN SCALE

Rate the severity of your **LOW BACK PAIN** by indicating on the following scale.

Absence [-----] Extreme

FOR OFFICE USE ONLY
SCORE: ____ / 50

NECK PAIN AND DISABILITY INDEX

Full Name: _____

Date: _____

This questionnaire has been designed to give us information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the one box that applies to you. We realise you may consider that two or more statements in any one section relate to you, but please just mark the box that most closely describes your problem.

Section 1: Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

Section 2: Personal Care (Washing, Dressing, etc.)

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help but can manage most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed, I wash with difficulty and stay in bed.

Section 3: Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently placed, for example on a table.
- Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights.
- I cannot lift or carry anything.

Section 4: Pain Intensity

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I can concentrate fully when I want to with no difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

Section 5: Headaches

- I have no headaches at all.
- I have slight headaches, which come infrequently.
- I have moderate headaches, which come infrequently.
- I have moderate headaches, which come frequently.
- I have severe headaches, which come frequently.
- I have headaches almost all the time.

Section 6: Concentration

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- The pain is moderate at the moment.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

Section 7: Work

- I can do as much work as I want to
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I can't do any work at all.

Section 8: Driving

- I can drive my car without any neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I can't drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive at all because of severe pain in my neck.
- I can't drive my car at all.

Section 9: Sleeping

- I have no trouble sleeping
- My sleep is slightly disturbed (less than 1 hr sleepless)
- My sleep is mildly disturbed (1-2 hrs sleepless)
- My sleep is moderately disturbed (2-3 hrs sleepless)
- My sleep is greatly disturbed (3-5 hrs sleepless)
- My sleep is completely disturbed (5-7 hrs sleepless)

Section 10: Recreation

- I am able to engage in all my recreational activities with no neck pain.
- I am able to engage in all my recreation activities, with some neck pain.
- I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
- I am able to engage in a few of my usual recreational activities because of pain in my neck.
- I can hardly do any recreational activities because of pain in my neck.
- I can't do any recreational activities at all.

NECK PAIN SCALE

Rate the severity of your Neck Pain by indicating on the following scale.

Absence [-----] Extreme

FOR OFFICE USE ONLY
SCORE: ____ / 50