



**Dr. Darryl Roundy & Associates**

Thank you for choosing **Atlas Family 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 of our policies is important to our professional relationship. The following is a statement of 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 your treatment plan after they have had an opportunity to review your case.

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both the doctor and the 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 method 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 or 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 its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than 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 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. 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:

**Specializing in Atlas Orthogonal, Chiropractic Pediatrics and Extremity Care**

2310 Mildred St. W., Suite 130 // University Place, WA 98466 // p: (253) 460-4244 // f: (877) 841-5137



Dr. Darryl Roundy & Associates

FINANCIAL POLICY

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

**Insurance:** 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.

**Non-covered services:** If insured, your insurance covers chiropractic care that is curative, reasonable and necessary. By definition, they can interpret that some ongoing care is not under that category and may be denied, either during the course of care, or upon paper review or audit. **They may consider it to be maintenance, preventive, or purely wellness care, which is not a covered service.** If insurance denies payment or seeks reimbursement from us for ongoing visits deemed to be a non-covered service by the reasons listed above, the patient is responsible for payment of services. The patient accepts the responsibility to pay for treatment that is deemed a non-covered service by their insurance.

**Account balances:** 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 time of settlement. 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 \$30 service charge for returned or N.S.F. checks.

**Appointments:** If you are unable to make a scheduled chiropractic appointment, a phone call to reschedule or cancel your appointment is required. If you do not show up for an appointment and do not call to cancel your appointment, it will be to the doctor's discretion as 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.

For massage therapy, we require 24-hour notice for any cancellation or appointment needing to be rescheduled. Last minute cancellations or no-shows will result in a \$50.00 non-refundable fee that will not be billed to insurance and will need to be paid in full prior to any treatment received at our office. If you show up to your appointment late, you will be responsible for the full amount of the massage time scheduled (i.e. if you show up 20-minutes late for a 1-hour massage, you are responsible for the full 1-hour charge even though the full hour can not be performed); if you are using insurance for massage benefits, we can only bill your insurance for the amount of time massage is performed; the amount of time you were late will have to be paid at the time of service and can not be billed to your insurance.

**Record Copies:** You have the right to review your personal health care records. Fees for copying your personal health information/records are set by state regulators annually (WAC 246-08-400). The fees are a \$23 clerical fee plus \$1.02 per page for the 1st 30 pages and \$0.78 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 this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



**Dr. Darryl Roundy & Associates**  
**Authorizations and Releases**

**Patient Health Information and Privacy Policy**

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available here:

<http://www.cms.hhs.gov/SecurityStandard/Downloads/securityproposedrule.pdf>

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
5. Patients have the right to file a formal complaint with our privacy official about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

**Initial** \_\_\_\_\_

**Consent to Professional Treatment**

The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. The patient may refuse treatment at any time.

**Initial** \_\_\_\_\_

**Consent to Perform and Interpret X-rays**

The patient consents to the performance of x-rays as deemed necessary by the attending physician of this office. The patient acknowledges that certain risks are associated with x-rays. The patient, hereby states that they have no known limitations that would forbid the taking of x-rays. The patient further agrees that this office may seek outside interpretation of patient x-rays by a qualified professional not employed by this office. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third-party payor.

**Initial** \_\_\_\_\_

**Assignment of Benefits and Release of Records**

The patient hereby assigns benefits to be paid directly to this provider by all of their third party payors. This assignment is irrevocable. Failure to fulfill this obligation will be considered a breach of contract between the patient and this office. The patient authorizes this office to release any information required by a third party payor necessary for reimbursement of charges incurred.

**Initial** \_\_\_\_\_

**Financial Obligation and Appointment Policy**

The patient accepts full financial responsibility for services rendered by this practice. This office reserves the right to charge fair market value for missed appointments or appointments cancelled without any advanced notification required by this office. Payment in full is required for all services at the time of visit, unless alternative arrangements have been agreed to in advance. Patient accepts full responsibility for any fees incurred, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. Patient should direct any questions regarding this financial obligation and appointment policy to the clinic manager or physician. The patient further authorizes the practice to retain credit card, debit card, checking account or other payment source(s) supplied by patient to the practice for current and future charges, when incurred.

**Initial** \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_



**Dr. Darryl Roundy & Associates**

## Consent for Purposes of Treatment, Payment & Healthcare Operations (3/03)

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

I consent to the use or disclosure of my protected health information by Atlas Family Chiropractic, 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 the clinic/practice. I understand that analysis, diagnosis or treatment of me by Atlas Family Chiropractic 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 healthcare operations of the practice. Atlas Family Chiropractic is not required to agree to the restrictions that I may request. However, if Atlas Family Chiropractic agrees to a restriction that I request, the restriction is binding on Atlas Family Chiropractic. I have the right to revoke this consent, in writing, at any time, except to the extent that Atlas Family Chiropractic 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 Atlas Family Chiropractic 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 Atlas Family Chiropractic. The Notice of Privacy Practices for Atlas Family Chiropractic is also posted in the waiting room at 2310 Mildred St. W. Suite 130, University Place, WA 98466 and on the clinic website at [http://atlaschiro.com/privacy\\_policy/](http://atlaschiro.com/privacy_policy/). This Notice of Privacy Practices also describes my rights and duties of Atlas Family Chiropractic with respect to my protected health information.

Atlas Family Chiropractic 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 Atlas Family Chiropractic and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

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Signature of Patient or Personal Representative

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Printed Name of Patient

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Date of Signing

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Description of Personal Representative's Authority

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**(PLEASE PRINT) - All information will be strictly confidential.**

Patient's Name (First, MI, Last)		Birth Date	Age	Sex M F	Marital Status M S W D DP
Residence Address	City	State	Zip	Home Phone ( )	
Patient E-mail Address	If Child, Parent Or Guardian's Name		Height	Weight	
Name Of Employer	Address (with city, state and zip)		Business Phone ( )		
Occupation	<b>Patient's Social Security Number</b> - -		<b>Mobile Phone</b> ( )		
<b>Emergency Contact</b>	<b>Relationship To Patient</b>		<b>Phone</b> ( )		
Whom May We Thank For Referring You To Our Office?			Phone ( )		
Do You Have Medical Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	If No, How Do You Intend To Pay? <input type="checkbox"/> Check <input type="checkbox"/> Cash <input type="checkbox"/> Credit Card	Insurance Company Name, Address and Phone Number			
Subscriber's Name	Subscriber's ID Number	Group No.	Is It Through Your Employer? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name Of Spouse		Subscriber's Birth Date			
Medicare No.					
<p>CONSENT TO TREAT A MINOR: <i>I hereby authorize Atlas Family Chiropractic PS and whomever they designate as assistants to administer care to my</i></p> <p><input type="checkbox"/> son <input type="checkbox"/> daughter <input type="checkbox"/> grandson <input type="checkbox"/> granddaughter <input type="checkbox"/> _____</p> <p>(Name of Child) _____ Dated at (city) _____ (state) _____</p> <p>(Date signed) _____ (Signature) _____ (Witness) _____</p> <p><b>PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE.</b> <i>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.</i></p>					
Signed _____			Date _____		



Dr. Darryl Roundy & Associates
Pediatric History Form - page 1 of 2

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name: \_\_\_\_\_ S.S.#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Work Phone: \_\_\_\_\_

Sex: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Referred By: \_\_\_\_\_

Names of Parents / Guardians: \_\_\_\_\_

Purpose For Contacting Us? \_\_\_\_\_

Other Doctors Seen for this Condition: \_\_\_\_\_ N \_\_\_\_\_ Y, 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 Seizures Chronic Colds Headaches
Asthma / Allergies Digestive Problems ADHD Recurring Fevers Growing / Back Pains
Colic Bed Wetting Car Accident Temper Tantrums Other \_\_\_\_\_

Family History: \_\_\_\_\_

Previous Chiropractor: \_\_\_\_\_

Date of Last Visit: \_\_\_\_/\_\_\_\_/\_\_\_\_ Reason: \_\_\_\_\_

Name of Pediatrician: \_\_\_\_\_

Date of Last Visit: \_\_\_\_/\_\_\_\_/\_\_\_\_ Reason: \_\_\_\_\_

Are You Satisfied with the Care Your Child has Received There ? \_\_\_\_\_ N \_\_\_\_\_ Y

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: \_\_\_\_\_

Prenatal History:

Name of Obstetrician / Midwife: \_\_\_\_\_

Complications During Pregnancy ? \_\_\_\_\_ N \_\_\_\_\_ Y, List: \_\_\_\_\_

Ultrasounds During Pregnancy ? \_\_\_\_\_ N \_\_\_\_\_ Y, Number: \_\_\_\_\_

Medications During Pregnancy / Delivery ? \_\_\_\_\_ N \_\_\_\_\_ Y, List: \_\_\_\_\_

Cigarette / Alcohol Use During Pregnancy: \_\_\_\_\_ N \_\_\_\_\_ Y

Location of Birth: \_\_\_\_\_ Hospital \_\_\_\_\_ Birthing Center \_\_\_\_\_ Home

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Pediatric History Form – page 2/2

Birth Intervention: \_\_\_\_\_ Forceps \_\_\_\_\_ Vacuum Extraction
\_\_\_\_\_ Caesarian Section, Emergency or Planned?

Complications During Delivery ? \_\_\_\_\_ N \_\_\_\_\_ Y, List: \_\_\_\_\_

Genetic Disorders or Disabilities: \_\_\_\_\_ N \_\_\_\_\_ Y, List: \_\_\_\_\_

Birth Weight: \_\_\_\_\_ Birth Length: \_\_\_\_\_ APGAR Scores: \_\_\_\_\_

Feeding History:

Breast Fed: \_\_\_\_\_ N \_\_\_\_\_ Y, How Long: \_\_\_\_\_

Formula Fed: \_\_\_\_\_ N \_\_\_\_\_ Y, How Long: \_\_\_\_\_ Type: \_\_\_\_\_

Introduced to Solids at: \_\_\_\_\_ Months, Cows' Milk at \_\_\_\_\_ Months

Food / Juice Allergies or Intolerances: \_\_\_\_\_ N \_\_\_\_\_ Y, 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
\_\_\_\_\_ Respond to Visual Stimuli
\_\_\_\_\_ Hold Head Up
\_\_\_\_\_ Sit Up
\_\_\_\_\_ Cross Crawl
\_\_\_\_\_ Stand Alone
\_\_\_\_\_ Walk Alone

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? \_\_\_\_\_ N \_\_\_\_\_ Y

Is / has your child been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.) ? \_\_\_\_\_ N \_\_\_\_\_ Y, List: \_\_\_\_\_

Has Your Child Ever Been Involved in a Car Accident? \_\_\_\_\_ N \_\_\_\_\_ Y, List: \_\_\_\_\_

Has Your Child Been Seen on an Emergency Basis? \_\_\_\_\_ N \_\_\_\_\_ Y, List: \_\_\_\_\_

Other Traumas Not Described Above? \_\_\_\_\_ N \_\_\_\_\_ Y, List: \_\_\_\_\_

Prior Surgery: \_\_\_\_\_ N \_\_\_\_\_ Y, List: \_\_\_\_\_

Menarche: \_\_\_\_\_ N \_\_\_\_\_ Y, Age: \_\_\_\_\_

Childhood Diseases:

- Chicken Pox N / Y, Age \_\_\_\_\_ Mumps N / Y, Age \_\_\_\_\_
Rubella N / Y, Age \_\_\_\_\_ Whooping Cough N / Y, Age \_\_\_\_\_
Measles N / Y, Age \_\_\_\_\_ Other N / Y, Age \_\_\_\_\_

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