WASHLESKI CHIROPRACTIC & ACUPUNCTURE CENTER **Robert Washleski D.C., LAc.**
4 Walter E. Foran Blvd., Ste 304 Flemington, NJ 08822 **P. 908-806-6171 F. 908-806-6433**

Patient Name: ____ **Date:** ____________

Address_______________________ City________________ State __________ Zip Code ___________

H. Phone __________________W. Phone________________ Cell Phone _________________________

Email Address: ______________________

Sex M F Marital Status M S D W Date of Birth______________ Age___________

Occupation ____

Employer ____

Emergency Contact and Phone Number: ____

Referred by: ____

Have you ever received Chiropractic Care? Yes No If yes, when? ___________________

Name of most recent Chiropractor: ____

1. Past Health History:

A. Surgeries:

Date ____________________ Type of Surgery ____

____________________ ____

____________________ ____

____________________ ____

____________________ ____

B. Previous Injury or Trauma: ____

Have you ever broken any bones? Which? ____

C. Allergies: ____

2. Family Health History:

Do you have a family history of? (Please indicate all that apply)

□ Cancer □ Strokes/TIA's □ Headaches □ Heart disease □ Neurological diseases
□ Adopted/Unknown □ Cardiac disease below age 40 □ Psychiatric disease
Diabetes □ Other ______________ □ None of the above

Patient Name: ____Date: ____________

A. Deaths in immediate family:

Cause of parents' or siblings' death	Age at death

3. Social and Occupational History:

A. Job description: ____

B. Work schedule: ____

C. Recreational activities: ____

D. Lifestyle:

Hobbies: ____

Level of Exercise: ____

Alcohol Use: ____

Tobacco Use: ____

Drug Use: ____

Diet: ____

4. Medications:

Medication	Reason for taking

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Patient Name: ____Date: ___________

Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other ____________ □ None of the above
Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other ___________ □ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell
□ Strokes/TIAs □ Other _______________ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes
□ Other ________________ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections
□ Difficulty urinating □ Kidney disease □ Dialysis □ Other ______________________ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation
□ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools
□ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _________ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive
□ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia
□ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use
□ Other _______________ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other __________ □ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery
□ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other ______________________ □ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia
□ Psychiatric hospitalizations □ Other ____________ □ None of the above
Is there anything else in your past medical history that you feel is important to your care here? _________________

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Patient Name: ____Date: ___________

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fundraising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

___________________________________ ________________________
Signature of Patient of Representative Date

____
Printed Name

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Patient Name: ____Date: ____________

NEW PATIENT HISTORY FORM

Symptom 1 ___________________________________

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? ____
    - How did the symptom begin? ____
- What makes the symptom worse? (circle all that apply):
    - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): _____________________________
- What makes the symptom better? (circle all that apply):
    - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): ______________________
- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, stiff Other (please describe): ____
- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? ___________________________________
- Is the symptom worse at certain times of the day or night? (please circle)
    - No difference Morning Afternoon Evening Night Other ____________
- Have you received treatment for this condition and episode prior to today's visit?
    - No
    - Anti-inflammatory meds
    - Pain medication
    - Muscle relaxers
    - Trigger point injections
    - Cortisone injections
    - Surgery
    - Massage
    - Physical Therapy
    - Chiropractic
    - Other ____

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Patient Name: ____Date: ____________

NEW PATIENT HISTORY FORM

Symptom 2 ______________________________________

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? ____
  - How did the symptom begin? ____

- What makes the symptom worse? (circle all that apply):
  - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): __________________________________

- What makes the symptom better? (circle all that apply):
  - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): __________________________

- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, stiff Other (please describe): ____

- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? ____

- Is the symptom worse at certain times of the day or night? (please circle)
  - No difference Morning Afternoon Evening Night Other ______________

- Have you received treatment for this condition and episode prior to today's visit?
  - No
  - Anti-inflammatory meds
  - Pain medication
  - Muscle relaxers
  - Trigger point injections
  - Cortisone injections
  - Surgery
  - Massage
  - Physical Therapy
  - Chiropractic
  - Other ____

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Patient Name: ____Date: ___________

NEW PATIENT HISTORY FORM

Symptom 3 ________________________________

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? ____
  - How did the symptom begin? _______________________________________
- What makes the symptom worse? (circle all that apply):
  - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): __________________________
- What makes the symptom better? (circle all that apply):
  - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): ____________________
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, stiff Other (please describe): _____________________________________
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _______________________________
- Is the symptom worse at certain times of the day or night? (please circle)
  - No difference Morning Afternoon Evening Night Other __________
- Have you received treatment for this condition and episode prior to today's visit?
  - No
  - Anti-inflammatory meds
  - Pain medication
  - Muscle relaxers
  - Trigger point injections
  - Cortisone injections
  - Surgery
  - Massage
  - Physical Therapy
  - Chiropractic
  - Other ____________________________________

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Patient Name: ____Date: ____________

NEW PATIENT HISTORY FORM

Symptom 4 ___________________________________

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? ____
    - How did the symptom begin? ____
- What makes the symptom worse? (circle all that apply):
    - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): ______________________________
- What makes the symptom better? (circle all that apply):
    - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _______________________
- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, stiff Other (please describe): ____
- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? ___________________________________
- Is the symptom worse at certain times of the day or night? (please circle)
    - No difference Morning Afternoon Evening Night Other _____________
- Have you received treatment for this condition and episode prior to today's visit?
    - No
    - Anti-inflammatory meds
    - Pain medication
    - Muscle relaxers
    - Trigger point injections
    - Cortisone injections
    - Surgery
    - Massage
    - Physical Therapy
    - Chiropractic
    - Other ____

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Patient Name: ____Date: ____________

NEW PATIENT HISTORY FORM

Symptom 5 ________________________________

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? ____
  - How did the symptom begin? ____

- What makes the symptom worse? (circle all that apply):
  - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): ___________________________

- What makes the symptom better? (circle all that apply):
  - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____________________

- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, stiff Other (please describe): _____________________________________

- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? ________________________________

- Is the symptom worse at certain times of the day or night? (please circle)
  - No difference Morning Afternoon Evening Night Other ___________

- Have you received treatment for this condition and episode prior to today's visit?
  - No
  - Anti-inflammatory meds
  - Pain medication
  - Muscle relaxers
  - Trigger point injections
  - Cortisone injections
  - Surgery
  - Massage
  - Physical Therapy
  - Chiropractic
  - Other ____________________________________

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Patient Name: ____Date: ___________

NEW PATIENT HISTORY FORM

Symptom 6 _______________________________

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? ____
  - How did the symptom begin? ______________________________________
- What makes the symptom worse? (circle all that apply):
  - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): __________________________
- What makes the symptom better? (circle all that apply):
  - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____________________
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, stiff Other (please describe): _____________________________________
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _______________________________
- Is the symptom worse at certain times of the day or night? (please circle)
  - No difference Morning Afternoon Evening Night Other __________
- Have you received treatment for this condition and episode prior to today's visit?
  - No
  - Anti-inflammatory meds
  - Pain medication
  - Muscle relaxers
  - Trigger point injections
  - Cortisone injections
  - Surgery
  - Massage
  - Physical Therapy
  - Chiropractic
  - Other _____________________________________

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in the office, and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic and acupuncture office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own 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 the PHI. Or office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of the records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, Dr Washleski has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signature of Patient: ____ Date: ______________________

PLEASE PRINT NAME: ____

HUNTERDON COUNTY ACUPUNCTURE CENTER
Robert A. Washleski, DC, D.A.B.C.O., LAc.

ACUPUNCTURE INFORMED CONSENT

I hereby request and consent to acupuncture treatment and/or herbal supplement recommendations, on me (or my legal charge) by the licensed acupuncturist named above and/or other licensed acupuncturists who may treat me at the direction of the above named acupuncturist. In understand that the acupuncturist will explain all known risks and complications, and I wish to reply on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, is in my best interests. I may request another person of my choice to be present in the treatment room during treatment.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunction in the body. I understand the results are not guaranteed. While it is a safe method of treatment, it can occasionally cause mircohemorrages in the tissues. This bleeding usually resolves with pressing dry cotton on the local spot. There may also be a sensation of warmth, tightness, soreness, or tingling when the needle reaches the acupuncture point. This sensation is called "de qi" and is considered to be a normal response. It usually subsides soon after the needle is removed. There have been very rare instances reported of fainting, infections and scarring as a result of the needle insertion.

The acupuncturist is licensed by the State Medical Board of New Jersey to practice acupuncture as defined by the state. He is not a licensed medical doctor.

If any procedure is to be used in conjunction with acupuncture, such as those listed below, the acupuncturist will discuss them with me before my treatment begins. I understand that they may be beneficial in my treatment, hut that there is a particular risk to their use. I have read the information below and agree to the acupuncturist's use of this treatment (if indicated):

- **Traditional Chinese Herbal Supplements**: The supplements recommended are traditionally considered safe. However, I understand that some patients may experience gastro-intestinal upset or other reactions to the herbs. I will inform the acupuncturist immediately if I experience any side effects. I understand that some herbs may be inappropriate during pregnancy and may have damaging effects on the fetus. Recognizing the4se risks, I accept full responsibility to inform the acupuncturist of a suspected or confirmed pregnancy, or if I am a nursing mother.
- **Oriental Massage/Acupressure:** The technique of oriental massage may require disrobing. I understand all attempts will be made to assure my privacy.
- **Indirect Moxibustion:** This technique involves burning/smoldering an herbal material near the skin or on an acupuncture needle. Every precaution is taken to prevent skin contact, but the possibility of skin contact and burn exists.
- **Cupping:** This technique involves a localized suction produced by heating a small glass cup. There is a possibility of local bruising from the suction and slight burning or blistering due to the heat involved in the technique.
- **Gua Sha:** This technique involves vigorous local massage over a small area of skin. Local bruising is likely to occur at the site of where the Gua Sha is performed.
- **Tapping, Plum Blossom, Bleeding, Pricking:** These and similar techniques involve multiple needle pricks at a localized site. Slight Bleeding and/or bruising at the treatment side is likely to occur. This procedure will be performed with single use, disposable needles.
- **Electrical Stimulation/TENS:** This form of therapy uses microcurrent electricity to stimulate acupuncture points. A mild sensation of electric tingling or slight "pins and needles" will be felt.

I have read, or have had read to me, the above consent, and have also had the opportunity to ask questions and discuss this with the Acupuncturist. By signing below, I agree to acupuncture treatment, including the above named procedures for treatment of my present condition and any future condition(s) for which I seek treatment. I have the right to refuse or discontinue treatment at any time and understand that this refusal may affect the expected results.

______________________________________ __________________________

Signature of Patient (or guardian) Date

____

Patient's Name (please print)

The Washleski Chiropractic Center, P.C.
Hunterdon County Acupuncture
4 Walter E. Foran Blvd., Suite 304
Flemington, NJ 08822
(908) 806-6171 Fax (908) 806-6433

Office Policy Review

Introduction
The purpose of this review is to allow us to serve you and get the best results. It is out experience that those patients who adhere to the following policies get the best results.

Signing In
Please sign in. When your name is called your Healthcare Assistant will direct you to the appropriate treatment room.

Lectures
It is mandatory that all patients attend our Patient Health Consultation. This consultation explains how the body functions, how Chiropractic and Acupuncture work and how results are consummated, Family and friends are welcome. There is no charge for the Patient Health Consultation

Classes and lectures on different aspects of health care are often scheduled and may be attended at no cost. Please bring family and friends. Look for announcements regarding classes.

Canceling or Changing Appointments
The Doctor has prepared a specific course of treatment for you to get the results we both desire. If you need to change the time of your appointment, plan to come at another time of the day. If the same day is not possible, be sure to make up the missed appointment <u>within 1 week</u>.

Progress Evaluations and Reexaminations
During your Treatment sequence, progress evaluations and reexaminations make take place. You will be advised of your progress and need for future care.

Diets and Food Supplements
Diets should be followed and food supplements taken as recommended by the Doctor. Any problem you may have with these recommendations should be communicated with the Doctor.

Answering Service
In the event that we are unable to answer your call our phone answering machine automatically picks up the phone. Please leave a message to include your name, phone number, time you are calling and whether or not it involves an emergency.

Emergency Policy
We realize that from time to time health emergencies arise. The Doctor calls the answering machine for messages after office hours and throughout the weekend. So if any emergency arises please call. The Doctor will call you.

Referral Policy
It makes each of us feel great that we are able to help so many. If you have a friend or relative that you feel may have a chiropractic or acupuncture problem, have them schedule an interview to talk to the Doctor at no charge. As with all our patients, if yours is a chiropractor or acupuncture problem we will let you know and, if not, be assured we will refer you to the proper specialist.

Hours
Monday, Tuesday, Wednesday & Friday: 9 A.M.- 12 Noon, 3 P.M.- 7 P.M.

Thursday: 3 P.M. – 7 P.M.
Saturday: 8:30 A.M. – 11 A.M.

X-rays
X-rays are the property of the clinic. Please see the receptionist about copies or X-ray reports.

Payment of Bills
We will expect you to honor the financial arrangements you will make with our office. If you find that you cannot fulfill the agreement you have made with us, advise our financial manager immediately so new arrangements can be made. Failure of the patient to make payment or to otherwise communicate will result in prompt legal action.

Worker's Compensation

Patient Payment
Approved Services for injuries covered by Worker's Compensation are covered 100% by insurance

Explanation of Benefits
Worker's Compensation covers all examination, treatment and x-ray costs once care has been authorized. Your employer has the right to decide whether to grant authorization for treatment of not. Authorization can also be granted by your supervisor on the job. If authorization is refused, the patient may receive treatment using alternate payment methods and plans.

Office Policy: Patients involved in a Worker's Compensation case must bring signed authorization for treatment to our office. If signed authorization for treatment is not brought to our office by your second visit, the balance will be transferred to your account. Compensation cases that involve lawsuits are expected to be paid for by your insurance or by yourself, not your attorney or court settlement. If your insurance carrier refuses payment, due to a lawsuit pending, your will be notified and the bill will be submitted to your group health insurance or paid by you. To aid us in this matter, please notify our office as to your attorney's name and address

Personal Injury Patients: (car accident, home accident)
On most insurance policies there is a deductible. You are personally responsible for all services rendered until the deductible is met. Once the deductible is met our office policy requires you to pay the co-payment. Payment is expected at the time services are rendered.

Insurance Patients
For your convenience, we have a qualified insurance staff to handle your insurance claims. We ask that you fill out our insurance questionnaire and provide us with your insurance cards and drivers license so we can photocopy them. You are responsible for any deductible due, plus any co-payment. We will submit your insurance to your insurance carrier. You are responsible for any charges that the insurance carrier will not pay. Payment of your co-pay balance will be due at the time services are rendered or as per your financial agreements. Personal balances of the co-pay due cannot exceed $100.

Non-Insured Patients
Per visit payment is due in full. We do accept cash, check, VISA and Mastercard. Services are to be paid for in the date they are rendered. It may be necessary to do a credit check.

If a need to change your financial arrangements arises, please talk to our financial manager immediately.

Our Healthcare Assistants are here to read over these office policies with you and answer any questions you may have.

The purpose of *The Washleski Chiropractic and Acupuncture Center* is to Support Each Individual in Achieving Their Optimum Health in as Many Health Paradigms as Possible. To Educate Them so that They May Understand Health and in Turn Educate Others.