WhisperingFalls
MASSAGE THERAPY

**Patient Consent for use and Disclosure of Protected Health Information**

I hereby give my consent for Whispering Falls, Inc. to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Whispering Falls, Inc. describes such uses and disclosures more completely.)

I have the right to review the *Notice of HIPPA Privacy and Novel Coronavirus Notice* prior to signing this consent. Whispering Falls, Inc. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Whispering Falls, Inc. Attn: Privacy Officer, 13701 E. Sprague Ave. Spokane Valley WA 99216.

With this consent, Whispering Falls, Inc. may call my home or other alternative location and leave a voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Whispering Falls, Inc. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Whispering Falls, Inc. may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Whispering Fall, Inc. restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Whispering Falls, Inc. to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Whispering Falls, Inc. may decline to provide treatment to me.

_____
**Signature of Patient or Legal Guardian**

_____ _____
**Print Patient's Name** **Date**

**Names of People that you would like to have full access to your PHI (such as billing information, appointments, and health records).

_____ _____
Name of Person & Relationship to insured Name of Person & Relationship to insured

_____ _____
Name of Person &Relationship to insured Name of Person & Relationship to insured

**Whispering Falls Massage Therapy**

Date: _____ Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

☐ I agree to receive text messages to the cell phone above reminding me about my upcoming appointments with Whispering Falls Massage therapy. I understand that SMS reminders are optional and that message and data rates may apply.

Date of Birth: _____ Email Address: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Emergency Contact: _____ Phone: _____

Were you injured? ☐ Yes ☐ No If yes, Date of Injury:_____ ☐ Work Injury ☐ Auto Accident

Employer: _____

Address: _____ City: _____ State: _____ Zip: _____

**Whom may we thank for referring you to our office:** _____

## Health History

| | | |
|---|---|---|
| ☐ Bone or Joint Disease | ☐ Constipation/Diverticulitis | ☐ Sinus Problems |
| ☐ Tendonitis/ Bursitis/ Arthritis | ☐ Cancer/Tumors (Past/Present) | ☐ Sprains/Strains |
| ☐ Irritable Bowel Syndrome | ☐ Neck, Shoulder, Arm Pain | ☐ Herpes/Shingles |
| ☐ Headaches/Head Injuries | ☐ Numbness/Tingling | ☐ Spasms/Cramps |
| ☐ Chronic Pain | ☐ Jaw Pain/TMJ | ☐ Fatigue |
| ☐ Heart Condition | ☐ Sleep Disorder | ☐ Blood Clots |
| ☐ High/Low Blood Pressure | ☐ Breathing Difficulty | ☐ Lymphedema |
| ☐ Depression | ☐ Disease Name(s) _____ | ☐ Allergies _____ |
| ☐ Pregnant? Stage: _____ | ☐ Medications: _____ | |

## IMPORTANT

## Please Read, Initial, Sign and Date

_____There will be a $70.00 fee (per massage hour) for appointments cancelled, with less than a 24-hour notice and for no-shows. A one-hour full body massage is based upon a 50-minute professional hour. This allows you 5 minutes to disrobe and 5 minutes to re-clothe yourself. In consideration of others, we ask that you please be on time for your appointment.

### Insurance Clients

_____ As a courtesy we will be more than happy to check your insurance for eligibility and benefits. This is NOT a guarantee of coverage. You should be aware of your yearly maximum, frequencies, deductibles, waiting periods and limitations. We expect your ESTIMATED portion at time of service (unless prior arrangements have been made.) You are responsible for any portion not paid by your insurance carrier 90-days from date of service. We recommend that you reach out to your insurance company as well for confirmation of benefits.

### Payment at Time of Service

_____ Co-pays, co-insurance and deductibles are due at time of service. A $10 service fee will be charged for copays, co-insurance or deductibles not paid at time of service

*Information about the ESTIMATED charges of your health services is available upon request. Please do not hesitate to ask for information.

Thank you for your consideration.

**Signature:** _____ **Date:** _____

WhisperingFalls
MASSAGE THERAPY

# AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges you incurred.

2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you, based in whole or in part upon the charges made for your services.

3. In the event any insurance company obligated, by contractual agreement, to make payment to me or to you for the charges made for your services, refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent date) and authorize you to prosecute and take action in my name as you see fit and further authorize you to compromise, settle or otherwise receive and claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed directly from me. I understand that whatever amounts you do not collect from the insurance company's proceeds, whether it is all or part of what is due, I personally owe and agree to pay to you.

4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this State of Washington.

5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.

6. This Authorization and Assignment will be in continual effort until revoked by both parties.

_____ _____

Date Patient/Insured Signature

## LIEN AND INSTRUCTIONS TO COUNSEL

I, the undersigned, understand that all past, present and future bills incurred at the Clinic noted below, are my responsibility for payment. I hereby ratify my agreement to pay all bills incurred during my health care at this Clinic.

In consideration for the below-named Clinic having agreed to treat me without payment at the time of service and enabling me to obtain treatment from accident/injury/illness, without financial hardship, I give you a lien on any settlement, clear judgment, verdict or result of accident/injury/illness and I agree to irrevocably instruct my attorney to pay you in full from any proceeds of settlement, claim or judgment to this accident/injury/illness.

I also understand that if the settlement does not cover my entire bill at this Clinic, I am still responsible for the remainder, and the payment by me of this bill is not contingent on any settlement, claim or judgment which I may eventually recover.

Furthermore, in consideration for the below-named Clinic refraining from attempting to collect immediate payment for services rendered for my accident/injury/illness, I do hereby waive and toll any applicable statute of limitations on the collection of my account until I notify the Clinic of the conclusion of my efforts to obtain a settlement of judgment through the assistance of my attorney, and for a period of three (3) months thereafter.

wf | WhisperingFalls
CHIROPRACTIC, P.S.

**13701 E. Sprague Ave**
**Spokane Valley, WA 99216**
**509-922-5585**

Clinic Name and Address

_____
Patient Name (Please Print)

_____
Patient Signature

_____
Date

## INSTRUCTIONS TO COUNSEL

I do hereby irrevocably instruct you, my Attorney, named below, to pay Clinic named above in full for services to me for my accident/injury/illness from any proceeds or settlement, claim or judgment regarding said accident/injury/illness. You are to pay the Clinic prior to distributing any proceeds to me, and I instruct you not to attempt to reduce by means of negotiation my doctor's bill for the services that have been provided to me for the accident/injury/illness which I have agreed to pay in full.

_____
Firm Name

_____
Patient Signature

_____
Attorney Name

_____
Date