GREEN LAKE HEALTH CENTER
9714 3rd Ave NE SUITE 103 • SEATTLE, WA • 981115 • PHONE (206) 527-9709 • FAX (206) 526-2991

Patient Name: Date of Birth:

Address: City: State: Zip:

Occupation: Employer:

Email: Is it ok to receive emails from us? □Yes □ No

Marital Status: □ Single □ Married □ Divorced □ Other:

□ Home#: □ Cell#: □ Work#:

Emergency Contact Name: Telephone#: Is it OK to leave a message □Yes □ No

PRIMARY HEALTH INSURANCE: Policy / I.D#:

Group / Plan #: Are you the primary subscriber of the insurance plan: □Yes □ No

Name of Subscriber: Subscribers Date of Birth: Subscribers Gender:

What is your relationship to the subscriber? Subscribers Employer:

SECONDARY HEALTH INSURANCE: Policy / I.D#:

Group / Plan #: Are you the primary subscriber of the insurance plan: □Yes □ No

Name of Subscriber: Subscribers Date of Birth: Subscribers Gender:

What is your relationship to the subscriber? Subscribers Employer:

AUTO ACCIDENT (We Only Accept 1st Party Claims) Insurance Company Name:

Claim #: Date Opened: Date of Injury:

Adjusters Name: Telephone#:

WORKERS COMPENSATION CLAIMS: L&I □Yes □ No (If No) Insurance Company Name:

Claim #: Date Opened: Date of Injury:

Adjusters Name: Telephone#: Attending Physician:

Please read and initial each line below:

____ **Payment Agreement:** All payments are due at the time of service, unless other arrangements have been made in advance. All professional services rendered are charged to the patient and the patient is responsible for all fees, regardless of insurance coverage. I agree that that any payment by my insurance carrier for services performed by GLHC will be assigned to GLHC for payments of amounts owed.
I understand I am responsible for charges not covered by this assignment including finance charges, non-covered services, deductibles, co-payments, and co-insurance payments required by my insurance policy or certificate. I further agree that in the event of non-payment, I will bear the expenses of collection and/or court costs and/or reasonable legal fees, should this be required. I understand if my commercial insurance has not paid my bill within 60 days of my visit(s) for my services received by GLHC, I am responsible and I will then make whatever arrangements are necessary and available to me to pay all unpaid charges.

_____ GLHC will do an insurance verification as a guideline, I understand the information collected is done as a courtesy and GLHC can make no guarantees as to the payment from my insurance carrier. I am responsible for knowing my benefit, coverage, limitations and requirements.

_____ I agree to cancel my appointments at least 12 hours in advance or be charged a fee of half the normal hourly rate. Calls received after normal business hours will be considered to be received at the time our office opens the following day. Any same day cancellation is considered to be a late cancel. If you **do not inform us** of your cancellation before your scheduled appointment time, this is considered a no-show and the fee will NOT be waived. We reserve the right to assess higher fees for excessive late cancellations and no-shows.

_____ I agree **i**t is my responsibility to notify GLHC of any changes pertaining my personal information and/or health history prior to treatment.

_____ I understand my therapist does not diagnose illness, therefore I must have a prescription on file at the time of service. I agree my therapist may not treat areas unrelated to such prescription and I may be asked to get a new prescription if deemed necessary by my therapist.

____ I hereby authorize Green Lake Health Center, to **release any and all medical information** to insurance carrier(s), my designated attorney, now or in the future, and/or to my physician(s), if necessary, for the purposes of payment of my medically related outstanding debts, administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of this signing until revoked in writing, to both my insurance carrier and to the provider of services. GLHC will charge a reasonable fee for medical records when allowed by State Statute or Workers' Compensation Statute.

HEALTH HISTORY

Y N Have you ever had professional massage therapy treatment?	Y N Do you have high blood pressure?
Y N Have you ever had professional acupuncture before?	Y N Are you pregnant? If so, how far?
Y N Do you have arthritis?	Y N Do you have spinal problems?
Y N Do you have varicose veins or blood clots?	Y N Do you have any contagious or infectious diseases?
Y N Do you wear contact lenses?	Please list:

Y N Do you exercise regularly? Please describe:

Y N Do you take any medications? Please list and indicate what they are treating:

Y N Have you ever had surgery? Please list:

Y N Have you recently suffered a severe injury or illness? Please describe:

Y N Do you have any skin problems or allergies? Please list:

Y N Do you have any areas that need special attention? Please describe:

The majority of my pain is located:

To answer the questions below, please use the following scale to rate your pain: 0 = No Pain; 5 = Moderate Pain; 10 = Worst Possible Pain

With no activity my pain intensity is	0 1 2 3 4 5 6 7 8 9 10	Is it constant? Y N	
When I lift	0 1 2 3 4 5 6 7 8 9 10	When I dress	0 1 2 3 4 5 6 7 8 9 10
When I read	0 1 2 3 4 5 6 7 8 9 10	When I walk	0 1 2 3 4 5 6 7 8 9 10
When I work	0 1 2 3 4 5 6 7 8 9 10	When I sit	0 1 2 3 4 5 6 7 8 9 10
When I drive	0 1 2 3 4 5 6 7 8 9 10	When I stand	0 1 2 3 4 5 6 7 8 9 10
When I sleep	0 1 2 3 4 5 6 7 8 9 10	When I type	0 1 2 3 4 5 6 7 8 9 10

Are there any other daily activities that your pain has affected? What are they and how?

If you have been involved in an accident please provide a description of what happened.

Important Information to know and remember.

- We check all patients files 2 days in advance, so when making follow up appointments please be sure to have a valid prescription that covers the date range and number of visits you are making appointments for.
- Please check in at the front desk before your appointment.
- We are a Fragrance Free Environment. Please do not wear fragrances to your appointments.

This is a place of healing. We do not allow threats or aggression. We value the safety of our patients and all who work here.

Signature: **Date:**