Finnigan CHIROPRACTIC

New Patient Paperwork

Demographic Information

Patient Name (As Appears on Insurance Card)

Preferred Name DOB SSN

Parent/Guardian Name (if applicable)

Sex at Birth: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Separated/Divorced ☐ Widowed

Address

City State Zip Email

Cell Phone Home Phone

Spouse/Partner Name Phone Number

ER Contact Relationship Phone Number

Employment Status: ☐ Part Time ☐ Full Time ☐ Self Employed ☐ Homemaker ☐ Unemployed ☐ Retired

Occupation Employer

Primary Care Physician

Who may we thank for referring you?

Insurance Information

☐ Cash ☐ VA ☐ Workers Compensation Auto Accident: ☐ At Fault ☐ Not At Fault

Date of Accident (if applicable)

Our massage therapists are **not** currently contracted with most major medical plans. You may attempt to submit a member claim to your insurance company for reimbursement; however, we are unable to provide diagnosis and procedure codes.

We accept TriWest VA with a valid authorization, workers compensation, car accident and personal injury protection claims. **Please note, if you were not at fault and coverage is being provided by a 3rd party auto insurance, we require a letter of representation from your attorney to hold billing until your claim is resolved**

Do you have Personal Injury Protection (PIP) through your auto insurance? ☐ Yes ☐ No ☐ Not Sure

Insurance Name Claim #

Claim Adjustor Phone #

Attorney Name Phone #

No Show Policy

We value your time and are committed to providing personalized, high-quality care. To best serve all our patients, we have implemented the following No-Show Policy:

A **"no-show"** is defined as a missed appointment without prior notice to cancel or reschedule. This includes patients who arrive more than **15 minutes late** and cannot be accommodated due to scheduling constraints.

- **Chiropractic Appointments**: A **$30 fee** may be charged to your account if an appointment is missed without any communication.
- **Body Sculpting Appointments**: A **$50 fee** may be charged to your account for missed appointments without 24 hours' advanced notice.
- **Massage Appointments**: A **$100 fee** may be charged to your account for missed appointments without 48 hours' advanced notice.
- **Repeated No Shows**: In addition to incurring the above listed fees, you may be required to pre-pay or leave a deposit for future appointments.

Why This Policy Is Important
Missed appointments disrupt continuity of care and limit appointment availability for other patients in need. Repeated no-shows may result in delayed treatment outcomes and could impact your overall health progress.

How to Cancel or Reschedule
For your convenience, we have several methods of communication including:

- Phone (360) 459-7800
- Text (360) 523-1261
- Email frontdesk@finniganclinic.com.

If it's outside of regular hours, please leave a voicemail or send an email. We understand that things happen and will take extenuating circumstances into consideration.

Financial Agreement

The above information is true and accurate to the best of my knowledge. I understand and agree that medical and accident insurance coverage is a contract between me and my insurance company and/or employer. It is my responsibility to know my insurance benefits and whether a referral or prior authorization is required. I understand that I am financially responsible for all services provided by Finnigan Chiropractic, and I agree to promptly pay all invoices from this office. I also understand and agree to notify the office immediately of any insurance or demographic changes.

I understand that these policies may change without notice and that a copy of this agreement is available upon request.

Patient Name _____

Parent/Guardian Name _____

Signature _____ Date _____

Notice of Privacy Practices

Finnigan Chiropractic is committed to protecting the privacy and confidentiality of your protected health information as required by the Health Insurance Portability and Accountability Act (HIPAA).

Our Notice of Privacy Practices describes:

- How medical information about you may be used and disclosed
- Your rights regarding your health information
- How you can obtain access to this information

A copy of our current Notice of Privacy Practices is available upon request.

I acknowledge that I have been offered a copy of Finnigan Chiropractic's Notice of Privacy Practices.

Authorization to Release Information

I authorize Finnigan Chiropractic to discuss my care, appointments, billing, and/or protected health information with the following individuals:

Name	Relationship	Phone Number

I understand I may revoke my authorization to release information to the above-named individuals at any time.

☐ I do not authorize release of information to anyone other than myself.

Communication Preferences

Please select approved/preferred methods of communication:

☐ Phone Call ☐ Voicemail ☐ Text Message ☐ Email

I understand that standard text messaging and email may not always be secure forms of communication.

Patient Name _____

Parent/Guardian Name _____

Signature _____ Date _____