Acknowledgement of Financial Responsibility

INDIVIDUAL'S FINANCIAL RESPONSIBILITY. I understand that I am financially responsible for time spent with ANY PROVIDER at Houk Chiropractic Clinic **unless** the appointment has otherwise been pre- determined a "consultation".

Should I choose to involve my health insurance, the deductible, co-pays coinsurance, or non-covered services are ultimately my responsibility. Payments are due at time of service unless otherwise discussed, or a financial arrangement has been made. If insurance coverage is discovered after my date of service, Houk Chiropractic will be willing to "retro" bill any dates of service within the timely filing limits established by my personal insurance company. I understand that it is my responsibility to provide Houk Chiropractic accurate insurance information and that failure to do so may result in a denial of my claim.

As stated by my insurance company, a "quotation of benefit is not a guarantee of coverage or payment" and is dependent upon eligibility and medical necessity. Patient responsibility is determined by the insurance company. Claims are processed, and current insurance policies are applied.

Any pre-collected funds will be applied to the date of service, and I will be billed the difference when applicable. I understand that any pre-collection is an estimate based on the quote from my insurance company, and a courtesy performed for me by Houk Chiropractic.

In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided. If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

____

Signature of Patient or Authorized Representative / Date

____

Print Name of Patient or Authorized Representative / Relationship to Patient

Houk Chiropractic Clinics

NPI: 1528046778, TIN: 91-11161034
3809 N Monroe Spokane WA 99205 *** 9720 N Nevada Spokane WA 99218
Monroe: 509-326-3795 *** Northpointe: 509-464-2273

Good Faith Estimate - 10/01/2025

Patient Name:			Date of Birth:		
Diagnosis					
Estimated Services and Items	**Date of Appointment**				
Description	**Service Code**	**Quantity**	**Expected Cost**		
			Payment plan	Time of service	
Evaluation New Patient	99204	1	$ 300.00	$ 255.00	
Lumbar X-ray 5 view	72110	P	$ 140.00	$ 119.00	
Lumbar 4 view	72100	P	$ 90.00	$ 76.50	
Thoracic X-ray	72070	P	$ 90.00	$ 76.50	
Cervical X-ray	72050	P	$ 130.00	$ 110.50	
Cervical X-ray 3 view	72040	P	$ 95.00	$ 80.75	
Full spine X-ray		P	n/a	$ 225.00	Full spine; other x-ray charges will not apply
Spinal adjustment	98940	P	$ 55.00	$ 50.00	$ reflects cost per visit
Laser Treatment	0552T	P/R	$ 53.00	$ 48.00	
Guasha Treatment	97140	P/R	$ 45.00	$ 40.00	
Cost of Initial Visit may be reduced based on Level of Evaluation/X-Ray needs					
Established patient evaluation	99214	R	$ 200.00	$ 170.00	
Lumbar X-ray 5 view	72110	R	$ 140.00	$ 119.00	
Lumbar 4 view	72100	R	$ 90.00	$ 76.50	
Thoracic X-ray	72070	R	$ 90.00	$ 76.50	
Cervical X-ray	72050	R	$ 130.00	$ 110.50	
Cervical X-ray 3 view	72040	R	$ 95.00	$ 80.75	Full spine; other x-ray charges will not apply
Full spine X-ray		R	n/a	$ 225.00	$ reflects cost per visit
Spinal adjustment	98940	R	$ 55.00	$ 50.00	4 unit (60 min) Massage /$ reflects cost per visit
Massage Therapy*	97124	P/R	$ 95.00	$ 90.00	
Future treatment costs dependent on frequency of care; Costs above reflect single visit pricing					
P-Primary Service R- Re-occurring services or item (valid for 12 months from date of this form)					

Disclaimers:

There may be additional items or services that we recommend as part of the course of care that must be scheduled or requested separately and are not reflected in this good faith estimate.

The information provided in this good faith estimate is only an estimate of items or services resonably expected to be furnished the time this good faith estimate was generated. Actual items, services, or charges may differ from the good faith estimate.

You have the right to initiate the patient-provider dispute resolution process if the actual billed charges are $400.00 more than the good faith estimate.

Patient Signature ______________________________ **Date** ____________________

It is our policy to expect payment at time of service. We have prepared a payment plan for you. Our financial policy states: 20% or $ 75.00 of account balance, or whichever is greater, will be due each month. Default in regular monthly payments can result in collection procedures. Please contact our office if you have any further comments or questions. Patient Intials __________

☐ Patient opted to not receive Good Faith Estimate by mail prior to appointment -verbal estimate prior to visit was given. Staff Initial _______________

Houk Chiropractic Clinics – HIPAA Notice Child

Accident Information			
Is their condition due to an accident? ☐ No ☐ Yes Date:			
Type of Accident			
☐ Auto	☐ School	☐ Home	☐ Other
To whom have you made a report of your child's accident?			
☐ Auto Ins	☐ Other:		
Meaningful Use			
Preferred language: ☐ English ☐ Other :			
Child's Race:			
☐ White	☐ American Indian	☐ Alaska Native	
☐ Black	☐ African American	☐ Asian	
☐ Native Hawaiian	☐ Pacific Islander	☐ Other	☐ Decline
Child's Ethnicity:	☐ Hispanic-Latino	☐ Not Hispanic-Latino	☐ Decline

Please let us know the name(s) of anyone we may release your child's information to:
Name:
Relation

Name:
Relation:

Name:
Relation:

May we leave a detailed voicemail Y/ N

HIPAA Privacy Practice Notice

The Practice:

A: Is required by federal law to maintain the privacy of your Personal Health History and to provide you with this Privacy Notice detailing the practice's legal duties and privacy practices with respect to your Personal Health History.

B: Under the privacy rule, may be required by State law to grant greater access or maintain greater restrictions provided under federal law.

C: Is required to abide by the terms of this Privacy Notice.

D: Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your Personal Health History that it maintains.

E: Will distribute any revised Privacy Notice to you prior to implementation.

F: Will not retaliate against you for filing a complaint.

By signing my name below, I acknowledge receipt of a copy of this Notice, and I understand and agree to its terms.

All information provided on this document is true and correct to the best of my knowledge.

Assignment of Benefits

I authorize medical benefit payment, including Medicare, private and group insurance, or other health plan to Houk Chiropractic Clinic.

Print Child's Name: ____

Print Parent/Guardian's Name: ____

Parent/Guardian Signature: ____ **Date:** _____________________

Houk Chiropractic Clinics – Health History Child

Child's Name:	Birth Date:	Today's Date:
Reason for today's visit:		
Previous chiropractic care? ◻ No ◻ Yes If yes, when? With whom?		
What sports does/did your child participate in?		

Birth place: ◻ Home ◻ Birth Center ◻ Hospital ◻ Other	Type of birth: ◻ Vaginal ◻ Planned C-Section ◻ Emergency C-Section
◻ Premature ◻ Full-term | Delivered by: ◻ Midwife ◻ Obstetrician	Procedures: ◻ Forceps ◻ Vacuum extraction ◻ Other

Was delivery long? ◻ No ◻ Yes Time:	Was delivery difficult? ◻ No ◻ Yes	Induced? ◻ No ◻ Yes	Epidural? ◻ No ◻ Yes

Pain medication? ◻ No ◻ Yes	Was baby breech? ◻ No ◻ Yes	Was/is baby breast fed? ◻ No ◻ Yes For how long?

Did any of the following happen to mom during the pregnancy? Please check all that apply.

◻ Alcohol use	◻ Complications	◻ Medications	◻ Premature labor	◻ Vitamins/supplements
◻ Allergies	◻ Depression	◻ Mental trauma	◻ Prenatal care	◻ Weight loss
◻ Back pain	◻ Gestational diabetes	◻ Mostly happy	◻ Prenatal classes	◻ Other:
◻ Bleeding	◻ Immunizations	◻ New illness diagnosed	◻ Recreational drugs	
◻ Caffeine	◻ High blood pressure	◻ Physical injury	◻ Tobacco use	
◻ Chiropractic care	◻ Hospitalization	◻ Preeclampsia	◻ Toxic exposures	

Were any of the following involved with the child's birth?

◻ Bottle feeding	◻ Choking	◻ Jaundiced	◻ Pale in color	◻ Sleeping concerns
◻ Breast feeding	◻ Crying	◻ Medication	◻ Respirator	◻ Other:

Falls or Accidents

According to the National Safety Council, approximately 54% of infants fall head first from a high place (bed, changing table, etc) during the first year of life. Has this happened to your child? ◻ Yes ◻ No

Please list any falls or accidents:

Family History

Houk Chiropractic Clinics – Health History Child pg 2

Child's Name:			Today's Date:	
Has your child suffered any of these conditions? Circle "P" if in the distant past. Circle "R" if recent within the last 6 months.				
P / R ADD/ADHD	P / R Chronic colds	P / R Ear aches	P / R Head banging	P / R Seizures
P / R Allergies	P / R Clumsiness	P / R Ear infections	P / R Headaches	P / R Scoliosis
P / R Asthma	P / R Depression	P / R Easily fatigued	P / R Growing/back pain	P / R Temper tantrums
P / R Bed wetting	P / R Colic	P / R Eczema/Skin issues	P / R Nose bleeds	P / R Vomiting
P / R Bronchitis	P / R Constipation	P / R Fainting	P / R Not sleeping	P / R Walks "funny"
P / R Chiropractic care	P / R Digestive problems	P / R Falls often	P / R Recurring fevers	P / R Other
Medical				
Pediatrician's Name:			Date of last visit:	
Any problems during that visit?				
Current prescription medications:				
Past prescription medications:				
Over-the-counter drugs in the last six months:				
How many rounds of anti-biotics has your child taken in the last 6 months?				
Please list all of the child's surgeries and hospitalizations, including dates:				
Additional Information				

Child's Name: ____ Today's Date: _____________

Houk Chiropractic Clinics – Review of Symptoms

Allergic-Immunologic: ☐ **None**

☐ Hives/Eczema ☐ Hay Fever ☐ Catch cold easily ☐ Frequent Sinus Trouble ☐ Frequent Influenza
☐ HIV ☐ AIDS ☐ Allergies

Cardiovascular: ☐ **None**

☐ Murmur ☐ Chest Pain ☐ Palpitations ☐ Dizziness ☐ Shortness of Breath
☐ Swollen Ankles ☐ Heart Attack ☐ Irregular Heart Beat ☐ Pressure Over The Chest ☐ Pain Down the Left Arm
☐ High Triglycerides ☐ High Cholesterol ☐ Profuse Sweating ☐ Nausea ☐ Vomiting
☐ Low Blood Pressure ☐ Fainting Spells ☐ High Blood Pressure ☐ Difficulty Lying Flat

Constitutional: ☐ **None**

☐ Weight Loss ☐ Fatigue ☐ Fever

Ear, Nose, Throat: ☐ **None**

☐ Difficulty Hearing ☐ Buzzing in Ears ☐ Ringing in Ears ☐ Vertigo ☐ Sinus Trouble ☐ Nasal Stuffiness
☐ Hearing Loss ☐ Ear Pain ☐ Mouth Sores ☐ Hoarseness ☐ Nose Bleeds ☐ Dental Problem
☐ Frequent Sore Throat ☐ Difficulty Swallowing

Endocrine: ☐ **None**

☐ Loss of Hair ☐ Heat/Cold Intolerance ☐ Hypothyroidism ☐ Hyperthyroidism ☐ Diabetes ☐ Goiter

Eyes: ☐ **None**

☐ Glasses/Contacts ☐ Eye Pain ☐ Light bothers eyes ☐ Double Vision ☐ Cataracts ☐ Vision Problems ☐ Glaucoma

Gastro-Intestinal: ☐ **None**

☐ Heartburn/Reflux ☐ Nausea/Vomiting ☐ Constipation ☐ Change in BMs ☐ Diarrhea
☐ Black or Bloody BM ☐ Gallbladder Problem ☐ Liver Problem ☐ Hepatitis ☐ Distress from greasy food
☐ Ulcers ☐ Heartburn ☐ Hiatal Hernia ☐ Colitis ☐ Blood in the stool
☐ Colon Cancer ☐ Abdominal Pain ☐ Burning in stomach ☐ Pancreatitis ☐ Jaundice
☐ Pain over stomach ☐ Mucus in stool

Genitourinary: ☐ **None**

☐ Burning/Frequency ☐ Blood in Urine ☐ Erectile Dysfunction ☐ Abnormal Discharge ☐ Leakage ☐ Incontinence
☐ Kidney Infection ☐ Sexual Difficulty ☐ Kidney Stones ☐ Loss of libido

Hematology/Lymph: ☐ **None**

☐ Easy Bruising ☐ Gums Bleed Easily ☐ Enlarged Glands ☐ Anemia ☐ Bleeding Disorder ☐ Sickle Cell Anemia ☐ Lymphoma

Musculoskeletal: ☐ **None**

☐ Joint Pain/Swelling ☐ Stiffness ☐ Muscle Pain ☐ Neck Pain ☐ Stiff Neck ☐ Back Pain
☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Bone Spurs ☐ Broken Bones ☐ Compression fracture ☐ Head Injury
☐ Back Injury ☐ Spinal trauma ☐ Birth trauma ☐ Birth defects ☐ Cancer ☐ Muscle weakness
☐ Muscular Dystrophy ☐ Scheuerman's disease ☐ Scoliosis ☐ Lupus ☐ Spina bifida ☐ Spondylolisthesis
☐ Arthritis ☐ Neck Injury ☐ Osteoporosis

Child's Name: ____ Today's Date: ______________

Neurological: ☐ **None**

☐ Loss of strength ☐ Numbness ☐ Headaches ☐ Heavy Head ☐ Tremors ☐ Memory loss
☐ Difficulty Speaking ☐ Multiple Sclerosis ☐ Parkinson's Disease ☐ Fainting ☐ Concussion ☐ Migraines
☐ Disorientation ☐ Loss of Coordination ☐ Difficulty in walking ☐ Stroke ☐ Alzheimer's Disease ☐ Weakness
☐ Disk Problems ☐ Light headed/Dizzy ☐ Epilepsy/Seizures ☐ Tingling

Psychiatric: ☐ **None**

☐ Anxiety ☐ Depression ☐ Mood Swings ☐ Difficult Sleeping ☐ Nervousness ☐ Tension

Respiratory: ☐ **None**

☐ Cough ☐ Coughing blood ☐ Wheezing ☐ Chills ☐ Chronic cough ☐ Pneumonia
☐ Asthma ☐ Superficial breathing ☐ Chest Pain ☐ Tuberculosis ☐ Bronchitis ☐ Emphysema
☐ Difficulty Breathing ☐ Lung Cancer

Integumentary (Skin): ☐ **None**

☐ Rash/Sore ☐ Lesions ☐ Itching/Burning ☐ Skin Problems ☐ Slow Healing ☐ Bruise Easily
☐ Psoriasis ☐ Change in moles ☐ Change in skin color ☐ Skin Cancer ☐ Scars ☐ Discolorations

Women: ☐ **None** Number of pregnancies _____ Currently pregnant: ☐ Yes ☐ No

☐ Hot Flashes ☐ Vaginal Discharge ☐ Nipple Discharge ☐ Menstrual Cramps ☐ Premenstrual Depression
☐ Lumps in breast ☐ Hysterectomy

Men: ☐ **None**

☐ Burning on urination ☐ Difficulty in starting urine ☐ Dripping Urination ☐ Prostate Trouble ☐ Prostate Cancer

General: ☐ None

☐ Recent weight gain ☐ Loss of sleep ☐ Recent weight loss ☐ Loss of Appetite ☐ Fatigue
☐ Polio ☐ Rheumatic Fever ☐ Cancer of any kind ☐Metal Rods ☐Pins
☐Screws ☐Staples ☐Any type of metal beneath the skin/piercing

FAMILY HISTORY

	Headaches	Neck/Back Pain	Poor Posture	Scoliosis	Arthritis	Osteoporosis	Asthma	Cancer	Diabetes	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Disease	Liver Disease	Other	Seizure	Stroke/TIA	Tuberculosis	Ulcer
Grandparent	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Half-sibling	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Houk Chiropractic Clinics – Demographics Child

Patient Identification		
First Name:		MI:
Last Name:		
Nickname:		
Birth Date:	Age:	Sex: ☐ M ☐ F
Social Security #:		

What is the child's condition related to? ☐ Auto Accident

☐ Accident in Someone Else's Home ☐ Other Accident

☐ Accident at Someone Else's Business ☐ Non Accident

Parent/Guardian Information	
Mother/Guardian:	Birth Date
Address	
City: State: Zip:	
Home Phone: Cell: TEXT Y / N	
Email:	
Employer:	
Occupation:	
Work Phone:	
Father/Guardian:	Birth Date
Address:	
City: State: Zip:	
Home Phone: Cell:	
Email:	
Employer:	
Occupation:	
Work Phone:	

Patient Contact Information
Home Address:
City: State: Zip:
Patient lives with: ☐ Mom ☐ Dad ☐ Both ☐ Other
Mailing Address:
City: State: Zip:
Best Phone #: ☐ Home ☐ Mom's Cell ☐ Dad's Cell ☐ Other

Authorization for Care of a Minor

I certify that I am the parent or legal guardian of (child's name):

____ .

☐ I authorize Houk Chiropractic to administer the care deemed necessary to the minor named above **without** the presence of their parent/guardian. This minor is permitted to attend visits alone or without the presence of their parent/guardian.

☐ I do **not** authorize Houk Chiropractic to treat this minor patient without the presence of their parent/guardian.

This authorization is effective until revoked by me in writing.

Signature of Parent/Guardian:

____

Who may we thank for referring you to us today?

Did you hear of our office from any of these sources?

☐ NEWSPAPER ☐ SIGN ☐ TV ☐ RADIO ☐ MAILING

☐ COMMUNTIY EVENT ☐ OTHER: