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 _____

MLS® Laser Therapy

PATIENT INTAKE FORM

HOUK CHIROPRACTIC & MEDICAL MASSAGE

PATIENT SECTION

Patient Name: _____ Birthdate:_____ /_____ /_____

Current Medications: _____

_____

Area of concern: _____When did symptoms begin? _____

What are your symptoms?_____

How did it happen? _____

Do you have a known sensitivity to lasers or use medication increases sensitivity to light?	No / Yes
Are you taking medication that is known to increase sensitivity to heat?	No / Yes
Are you currently being treated for and/or have active cancer?	No / Yes
Do you have seizure disorder triggered by light?	No / Yes
Are you currently using topical or systemic steroids?	No / Yes
Do you have a pacemaker?	No / Yes
Have you had a steroid injection in the last 3 weeks?	No / Yes

Do you have any body tattoos/piercings?	No / Yes	Location: _____
Do you have a neuro-stimulator?	No / Yes	Location: _____
Have you ever had a laminectomy?	No / Yes	Location: _____
Are you currently pregnant?	No / Yes	Trimester: _____

DOCTOR

OFFICE USE ONLY

Diagnosis/Area: _____

Treatment Plan: _____

Alerts (i.e. Tattoo/Stimulator/etc.): _____

Joules target:_____ Central Ray: _____

Protocol: _____

_____

Doctor signature *date*

CT

Joules/cm2: _____ X:_____ Y:_____ Time: _____

Patient Positioning: _____

_____

Laser Head Position: _____

_____

CT Initials *date*

MLS® Laser Therapy
CONSENT FORM

HOUK CHIROPRACTIC & MEDICAL MASSAGE

Like all forms of medical treatment, there are associated risks as well as benefits.

- Exposure to the eyes during the procedure may result in damage to the retina. To prevent this, the supplied goggles must be worn during all treatment sessions.
- Under certain situations a superficial burn of the skin could occur. This is based upon skin pigmentation, skin discolorations (i.e. tattoos), or the use of topical creams, lotions or analgesic balms. Avoid the use of any topical creams, lotions or analgesic balms before or immediately after your therapy treatment.
- I understand I may experience a slight increase in pain anywhere from 6 to 24 hours following the treatment. Topical or systemic steroids for pain or skin conditions may flare up symptoms, please notify our office right away.
- I understand that I will be treated with a state-of-the-art Class IV, FDA approved MLS Therapy Laser, which produces a painless invisible beam of light that stimulates the tissue to initiate the healing process. This can reduce recovery time, even post-operative, leading to a quicker return to work or other important activities.
- I understand that MLS Laser Therapy is an option, and I have been advised of the advantages the MLS Laser Therapy will offer me. I also understand that MLS Laser Therapy is not effective in all 100% of patients.

❍ **YES, I want to be treated with MLS Laser Therapy.**

I understand that my insurance will not be billed and I am fully responsible for the cost.
I clearly understand and agree that all services rendered by me are charged directly to me and that I am personally responsible for payment.

I will be responsible for any costs of collection, attorney's fees or court costs required to collect my bill. Upon delinquency, there will be a **$20 late fee** assessed to my account balance.

This agreement shall be governed in the state of Washington according to the laws. Venue if necessary, shall take place in the city of Spokane. A 1% interest will be calculated on overdue accounts.

Patient Name: _____ Date _____

Signature: _____

Parent/Guardian Signature: _____

Houk Chiropractic Clinics – Demographics

Patient Identification		
First Name:		MI:
Last Name:		
Nickname:		
Birth Date:	Age:	Sex: ☐ M ☐ F
Social Security #:		
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
What is your condition related to? ☐ Auto Accident ☐ Accident in Someone Else's Home ☐ Other Accident ☐ Work Related ☐ Accident at Someone Else's Business ☐ Non Accident		

Patient Contact Information		
Home Address:		
City:	State:	Zip:
Mailing Address:		
City:	State:	Zip:
Home Phone:		
Cell Phone:	TEXT Y / N	
Email:		

Employment Information
Status: ☐ Full-time ☐ Part-time ☐ None ☐ Retired ☐ Self
Occupation:
Employer:
Work Address:
Work Phone:
Student Status: ☐ Full-time ☐ Part-time ☐ None

Spouse Information
Name:
Birth Date:
Home Phone:
Cell Phone:
Employer:
Occupation:
Work Phone:

Emergency Contact Information
Name:
Relation:
Birth Date:
Home Phone:
Work Phone:
Cell Phone:

Who may we thank for referring you to us?

How did you hear about us?
☐ NEWSPAPER ☐ SIGN ☐ TV ☐ RADIO ☐ MAILING ☐ COMMUNTIY EVENT ☐ OTHER:

Houk Chiropractic Clinics – HIPAA Notice

Accident Information
Is your condition due to an accident? ☐ No ☐ Yes Date:
Type of Accident
☐ Auto ☐ Work ☐ Home ☐ Other
To whom have you made a report of your accident?
☐ Auto Ins ☐ Employer ☐ Workers Comp ☐ Other
Meaningful Use
Preferred language: ☐ English ☐ Other :
Smoking: ☐ No ☐ Yes # packs per ☐ day ☐ week ☐ month
Alcohol: ☐ No ☐ Yes # drinks per ☐ day ☐ week ☐ month
Race: ☐ White ☐ American Indian ☐ Alaska Native ☐ Black ☐ African American ☐ Asian ☐ Native Hawaiian ☐ Pacific Islander ☐ Other ☐ Decline
Ethnicity: ☐ Hispanic-Latino ☐ Not Hispanic-Latino ☐ Decline

Please let us know the name(s) of anyone we may release your 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 Name: _____

Signature: _____ **Date:** _____