GENERAL PATIENT INFORMATION:

Name _____
(Last) (First) (M.I.)
Home Address _____ City _____State _____Zip _____
Home Phone _____ Work Phone_____ Cell Phone _____
D.O.B. _____ Social Security # _____ Age_____
Sex: M F Single ____ Married ____ Divorced ____ Other ____
Name of spouse _____ Ages of children _____
Email_____ (will not be given out; only to keep you posted on in office activities)

Employer _____ Work Phone _____Ext._____
Work Address_____ City _____State _____
Zip _____

COMPLAINT AND HISTORY:

Reason for coming in today? _____
How long has this condition persisted/when did it begin?_____
Is the condition getting worse? ڤYes ڤ No ڤ Constant ڤ Comes and goes
Have you received medical treatment for this condition? ڤYes ڤ No
Have you received Chiropractic Care for this condition? ڤYes ڤNo
Who referred you? _____Medical Doctor_____
If you were not referred, how did you hear about us? _____

PAYMENT AND INSURANCE INFORMATION:

ڤ Cash ڤCheck ڤCredit Card ڤ Other _____
Do you have health insurance? ڤYes ڤNo
If you checked yes, please give your card to the staff so we can make a copy for our records and billing purposes.
Insurance Company Name_____
Insured Name _____
(Person whose name your insurance coverage is under) (Last) (First) (M.I.)
Your relationship to insured (if you are not policy owner) _____
Insured Address (*if same as above leave blank*)
_____ City _____State _____Zip _____
Home Phone _____ Insured S.S. # _____ Insured D.O.B. _____

Financial And Treatment Disclaimer PLEASE READ: <u>Our policy requires payments in full for all services rendered at the time of visit</u>, unless other arrangements have been made with the doctor or staff. If the account is not paid in full within 90 days of the date of service and no arrangements have been made, you will be responsible for legal fees, collection agency fees and any other expenses incurred in collecting your account. I authorize the staff to perform any necessary services needed during the diagnosis and treatment. I also authorize the provider and or managed care organization to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ **Date** _____
If a minor, guardian's signature _____

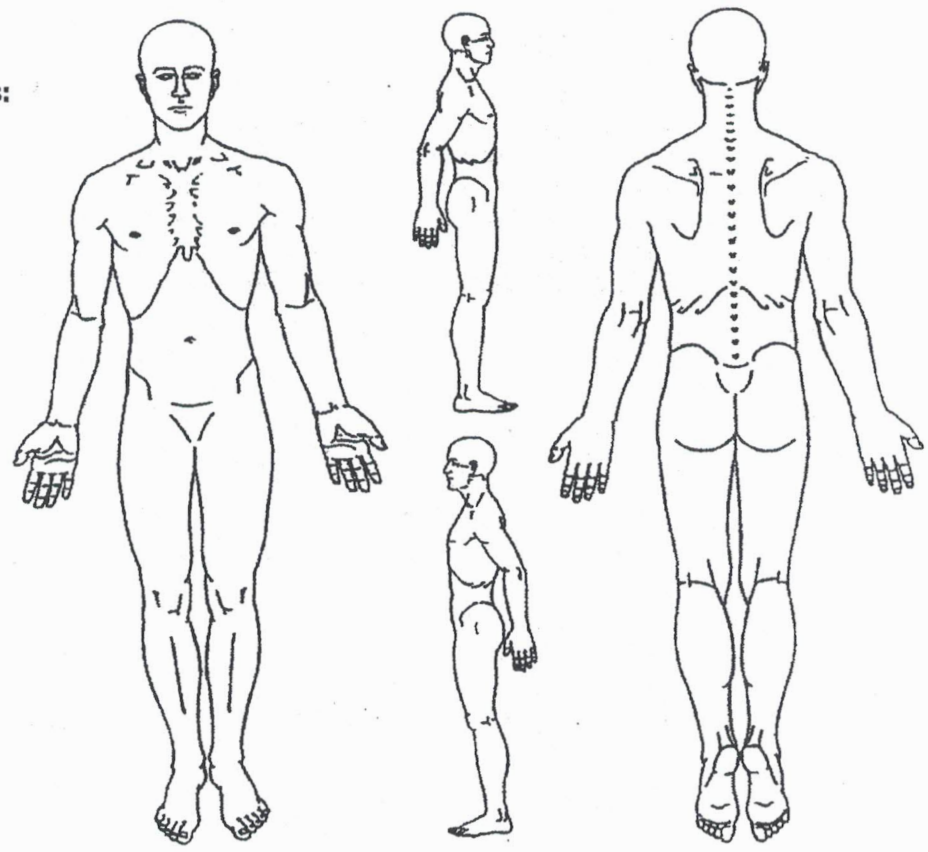
Office Use Only:
LYTEC _____
ROUTING SLIP ____
NEW PATIENT LETTER_____
INSURANCE VERIFIED _____

Your Name_____

Today's Date_____

Mark the body areas that are causing your pain using the following symbols:

A = Ache
B = Burning Sensation
S = Stabbing
N = Numbness
P = Pins & Needles
HA = Headache
O = Other briefly describe



Pain Scale

Circle the number that best describes your pain

1	2	3	4	5	6	7	8	9	10
None		Little			Medium				Severe

Brief Health History Past 10 Years

Recent Illness_____

_____

Past Hospitalizations_____

_____

Past Surgeries_____

_____

Other Major Illness_____

_____

Medications_____

_____

The above information is truthful and accurate.

SIGNATURE_____

if a minor, parent or guardian's SIGNATURE_____

INFORMED CONSENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I_____, Do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used.

Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware the there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor.

Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including, rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

_____ Signature of Patient Date_____

_____Signature of Parent or Guardian (if a minor) Date_____

_____Signature of Witness Date_____

To Our Patients Regarding Cancellations and No-Shows

The following are our policies regarding cancellations and no-shows. We take this subject seriously because it can make a difference between responding to treatment or not. Usually your referring doctor and/or therapist have prescribed a set frequency of treatment. If you show up for treatment, it will enable you to get better. Other than that all you need to do is follow your doctor's instructions, and you should achieve your treatment goals.

We require 24 hours notice in the event of a cancellation. This is to allow us to offer your appointment time to another patient who is in need. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get the full number of prescribed treatments that week whenever possible.

For **Workmen's Compensation and Personal Injury patients,** documentation of any missed appointments is forwarded to your case manager and primary physician. This could jeopardize your claim.

Please understand that your pain will probably increase and decreases as your course of treatment progresses and before it is finally eliminated. Either condition should not be a reason not to come in: 1) Your pain is gone or 2) Your pain is worse. If the pain is gone, now is the time to really begin rehabilitating the injured area to prevent recurrence. If your pain is worse, we can do something to help.

When you don't show as scheduled, three people are hurt. 1) You, because you didn't get the treatment you need as prescribed by your doctor; 2) The doctor who now has a hole in their schedule; 3) The person that couldn't get in when you had your appointment scheduled.

Thank you for cooperating with us on this matter. We are looking forward to working with you.

_____ _____

patient signature **date**

Active Chiropractic and Rehabilitation

INSURANCE VERIFICATION

- **Insurance verification if not a guarantee of payment.** Verification is only a quote of patient benefits. Insurance companies review charges individually and make payment accordingly. **Charges not covered by insurance are the patient's responsibility and due within 30 days of billing.**

DEDUCTIBLE PAYMENTS

- **It is our policy to collect at time of service.** Once we receive an "Explanation of Benefits" report from the patient's insurance company, we will bill or credit the account for the remaining balance. Reimbursement checks can be issued upon request.

COLLECTION OF PATIENT BALANCE

- Co-payments and co-insurance is the patient's responsibility and will be collected at the time of service.
- If the "Explanation of Benefits" report shows the patient has an outstanding balance from services not covered by the individual insurance company, patients will receive a bill outlining these outstanding charges. **Upon receipt, payment is due within 30 days. After 30 days, it is the clinic's policy to turn unpaid accounts over to a collection agency.**
- If your insurance denies payment, you will be billed the out of pocket rate of $90 for the initial consultation, and $47 per visit thereafter.

RETURNED CHECKS

- It is our policy to collect $25 for checks that are returned to us. This is to cover any fees that apply from the transaction.

APPOINTMENTS

- If unable to keep an appointment, as a courtesy to our staff and other patients please give 24 hour notice. If it is a continual problem there will be a **$20 charge** added towards your account each visit that is missed. The patient will be responsible for payment.

FINANCIAL POLICY QUESTIONS

- We are happy to address questions regarding your account at any time. Please direct accounting questions to our office at (812) 482-4269.

HIPPA PRIVACY POLICY

- Attached to the patient information packet at the back of these forms is the HIPPA Notice of Privacy Practices Policy for you.
- By signing below, the patient acknowledges that he/she has received the HIPPA Privacy Policy and that he/she understands and will comply with our financial policies.

_____ _____

Patient Signature Date

Active Chiropractic and Rehabilitation Clinic

HIPPA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW IT CAREFULLY

UNDERSTANDING YOUR HEALTH RECORD INFORMATION:

Each time you visit a hospital, physician, or healthcare provider, a record of your visit is made. Typically, this record contains you symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. This information often referred to as you health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its' accuracy, and better understand who, what, where, and why other may access your information, and make more information decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS:

Unless otherwise required by law, your record is the physical property of the healthcare practitioner or facility that complied it, the information belongs to you. You have the right to request a restriction on certain uses and disclosures of your information, and request amendments to your health record. This includes the right to obtain a paper copy of the notice of information practices upon request, inspect, and obtain a copy of your health record. Obtain an accounting of disclosures of your health information, request communication so your health information by alternative means or at alternative locations, revoke your authorization to use of disclose health information except to the extent that action has already been taken. Requests must be submitted in writing to the Privacy Officer (name and number listed on the last page of this notice). The practice may charge you a fee for the costs of copying, mailing, or other costs incurred by the practice in complying with your request.

OUR RESPONSIBILITY

This organization is required to maintain the privacy of your information. In addition, provide you with a notice as to our legal duties and privacy practices with respect of information we collect and maintain about you. This organization must abide by the terms of this notice, notify you if we are unable to agree to a requested restriction, accommodate reasonable request you may have to communicate health information by alternative means or at alternative location. We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices changes, we will mail a revised notice to the address you've supplied us. If we maintain a website that provides information about our customer services or benefits we will post our new notice on that website. We will not use or disclose your health information without your authorization, except as described in this notice.

FOR MORE INFORMATION OR TO REPORT A PROBLEM:

If you have questions and would like additional information, you may contact the Privacy Officer. If you believe your privacy rights have been violated, you can file a complaint with the Secretary of Health and Human Services. You may also provide complaints to the practice verbally or in writing. Such complaints should be directed to the practice's Privacy Officer. There will be no retaliation for filing a complaint.

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH OPERATIONS

We will use your health information for treatment. For example: Information obtained by a healthcare practitioner will be recorded in your record and used to determine the course of treatment that should work best for you. By way of example, your physician will document in you record their expectation of the member of your healthcare team. Members of your healthcare team will then record the actions they took and their observation. We will also provide your other practitioners with copies of various reports that should assist them in treating you.

We will use your health information for payment. For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill includes information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations. For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in you health record to assess the care and outcomes in you case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business Associates: There may be some services provided in our organization through contracts with Business Associates. Examples include physician services in the emergency department and radiology, and laboratory tests. When these services are contracted, we may disclose some or all of your health information to our Business Associate so that they can perform the job we've asked them to do. To protect your health information, however, we require the Business Associate to properly safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with Family: Health professionals, using their best judgment, may disclose to a family member, other relatives, close person friends or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Additional Uses and Disclosure Permitted Without Authorization or Opportunity to Object

In addition to treatment, payment and health care operations, the practice may use or disclose your protected information without your permission or authorization in certain circumstances, including:

When Legally Required: The practice will comply with any Federal, State, or local law that requires it to disclose your protected health information.

When There Are Risks to Public Health: The practice may disclose your protected health information for public health purposes, including to, as permitted or required by law:

- Prevent, control, or report disease, injury or disability
- Report vital events such as birth or death
- Conduct public health surveillance, investigations, and interventions
- Collect or report adverse events and product defects, track FDA regulated products, enable product recalls, repairs, or replacements, and conduct post marketing surveillance.
- Notify a person who has been exposed to a communicable disease(s) or who may be at risk of contracting or spreading a disease.
- Report to an employer information about an individual who is a member of the workforce to the extent within the worker's compensation laws and similar programs.

To Report Abuse, Neglect, or Domestic Violence: As required by law or with the patient's agreement, the practice may inform government authorities if it is believed that a patient is the victim of abuse, neglect, or domestic violence.

To Conduct Health Oversight Activities: The practice may disclose your protected health information to a health oversight agency for use in 1. Audits; 2. Civil, administrative, or criminal investigations, proceedings or actions; 3. Inspections: 4. Licensure or disciplinary actions; or 5. Other necessary oversight activities as permitted by law. However, if you are the subject of an investigation the practice will not disclose protected health information that is not directly related to you receipt of health care or public benefits.

Correctional Institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals. An inmate does not have the right to the Notice of Privacy Practices.

Law Enforcement: We may disclose health information for: law enforcement purposes as required by law or in response to a valid subpoena. When needed to identify or locate a suspect, fugitive, material witness, or missing person. When needed to report of crime and when you are the victim of a crime in a specific limited instance.

CONTACT PERSON

The practice's contact person regarding the practice's duties and your rights under the HIPPA privacy regulation is the Privacy Officer. The Privacy Officer can provide information regarding issues related to the Notice by request. Complaints to the practice should be directed to the Privacy Officer at the following address:

Active Chiropractic & Rehabilitation
725 W 6th Street
Jasper, Indiana 47546
Ph: (812) 482-4269
Fax: (812) 482-4269

www.jasperchiro.com

EFFECTIVE DATE: This Notice is effective on January 1st, 2016