WELCOME TO OUR OFFICE

First Name:	Last Name:	MI:	DOB:
Home Phone:	Cell Phone:	Work Phone:	
E-Mail		Preferred Communication: ☐ Home ☐ Cell ☐ Work ☐ E-Mail	
Street Address:			Apt/Suite #:
City:		Zip:	State:
SSN:	Sex: ☐ Male ☐ Female	Preferred Language: ☐ English ☐ Other:	

Race & Ethnicity: ☐ American Indian/Alaska Native ☐ Asian ☐ Hispanic/Latino ☐ Caucasian ☐ African American ☐ Other ☐ Native Hawaiian/Pacific Islander	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other
Emergency Contact Name:	Phone: Relationship:

Primary Insurance Coverage

Insurance Company:	Policy Holder Name:
Insurance ID #:	Group #:

Financially Responsible Party

☐ Self ☐ Other (Please Complete Section Below)

First Name:	Last Name:	DOB:
Home Phone:	Cell Phone:	Work Phone:
E-Mail:	Relationship:	
Street Address	Zip:	State:
Signature of Responsible Party:		Date:

Reason For Your Visit

☐ Pain Complaint/Ailment	Date of Onset:
Accident/Injury ☐ Automobile Related Accident Date of Accident: State: (Where Accident Occurred) ☐ Other	
If you are being seen for an <u>ACCIDENT OR INJURY,</u> please notify the front desk immediately.	
Please provide a brief statement regarding your pain and/or injury.	
Average Pain Intensity (circle one) Last 24 hours: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain) Past Week: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)	
What describes the nature of your symptoms? Sharp Ache Numb Shooting Burning Tingling Throbbing Other:	
How often do you experience your symptoms? Constantly Frequently Occasionally Intermittently	
Does anything help improve your pain and/or symptoms? **Yes / No If Yes, please explain:**	

Medical History

Are you pregnant? **Yes / No**	If yes, how far along?
Are you a smoker? **Yes / No**	If yes, how often?
Do you drink alcohol? **Yes / No**	If yes, how often?
Do you exercise? **Yes / No**	If yes, how often?

Have you ever been hospitalized? **Yes / No If yes, please provide dates and details**	

Have you ever had a **spinal**, **joint**, and/or **muscle**, **tendon**, or **ligament** surgery? **Yes / No** **If yes, please provide dates and details**	

Do you have any allergies? **Yes / No** **If yes, please provide details**
Do you require medical treatment for your allergies? **Yes / No**

Do you take any medications? **Yes / No** **If yes, please list all medications and dosages**

Please provide any other medical information you feel the doctor needs to know

Review of Systems – (Check box if you have had trouble with any of the following)

Cardiovascular	Yes	No	Past	**Respiratory**	Yes	No	Past	**Allergic/Immunologic**	Yes	No	Past
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Shortness of Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough				**Ear, Nose and Throat**			
High Cholesterol				Wheezing				Difficulty Swallowing			
Pacemaker				**Eyes**				Dizziness			
Jaw Pain				Glaucoma				Hearing Loss			
Irregular Heartbeat				Double Vision				Sore Throat			
Swelling of legs				Blurred Vision				Nosebleeds			
Genitourinary				**Psychiatric**				Bleeding Gums			
Kidney Disease				Depression				Sinus Infections			
Burning Urination				Anxiety				**Gastrointestinal**			
Frequent Urination				Stress				Gall Bladder Problems			
Blood in Urine				**Endocrine**				Bowel Problems			
Kidney Stones				Thyroid				Constipation			
Lower Side Pain				Diabetes				Liver Problems			
Neurologic				Hair Loss				Ulcers			
Stroke				Menopausal				Diarrhea			
Seizures				PMS				Nausea/Vomiting			
Head Injury				**Hematologic**				Bloody Stools			
Brain Aneurysm				Hepatitis				Poor Appetite			
Numbness				Blood Clots				**Musculoskeletal**			
Severe Headaches				Cancer				Gout			
Pinched Nerves				Bruising				Arthritis			
Parkinson's				Bleeding				Joint Stiffness			
Carpal Tunnel				Fever, Chills				Muscle Weakness			
Vertigo				Sweating				Osteoporosis			
Constitutional				Varicose Veins				Broken Bones			
Weight Loss/Gain								Joints Replaced			
Low Energy Level								Neck Pain			
Difficulty Sleeping								Low Back Pain			
								Upper Back Pain			

PAYMENT POLICY

Thank you for choosing Healthology Experts as your Chiropractic provider. We are committed to providing you with quality health care at an affordable price. To provide clarity to you regarding patient and insurance responsibility for services rendered, we have implemented this payment policy. A copy will be provided to you upon request. **Please read and initial the following paragraphs.**

____ INSURANCE. We participate in a variety of insurance plans. If we are not a provider with your insurance company or if your individual plan does not cover chiropractic care, payment is due in full at the time of service. You must provide an up-to-date insurance card at the time of your visit or you are responsible for the amount due. **It is your responsibility to know and understand your individual plan and the coverage provided.** If you have questions, please contact your insurance company. If your insurance company requires a referral from your Primary Care Provider, it is your responsibility to provide us with that referral PRIOR to your first visit.

____ CO-PAYMENT. All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments from patients can be considered fraud. Please help abide by the law by paying your co-payment at each visit.

____ PROOF OF INSURANCE. All patients must complete a patient intake form before seeing the provider. We must obtain a copy of your most current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

____ CLAIM SUBMISSION. We will submit claims to your insurance company when the visit is complete. Your insurance company may request that you provide additional information directly to them. It is your responsibility to comply with their request. Please be aware that the balance due is your responsibility if your claim is denied. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract.

____ COVERAGE CHANGES. If your insurance coverage changes, please notify us before your next visit so we can make the appropriate changes. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you.

____ MISSED APPOINTMENT. Kindly notify our office if you need to cancel an appointment at least 24 hours in advance. We reserve the right to charge a $25 no-show fee. **Please help us to serve you better by keeping your scheduled appointments**.

I have read and understand the payment policy and agree to abide by these guidelines.

_____ _____

Signature of patient or responsible party **Date**

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physiotherapy and diagnostic x-rays on myself (or the patient named below for whom I am legally responsible) by the doctor or intern affiliated with **HEALTHOLOGY EXPERTS**.

I understand that, as in the practice of medicine, and the practice of chiropractic care there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based on the facts then known, are in my best interest.

I have read, or have had read to me, the above statements. By signing below, I agree to the above and allow the doctor or intern affiliated with HEALTHOLOGY EXPERTS to perform such. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Signature of patient **Date**

CONSENT TO TREATMENT OF A MINOR CHILD

I hereby authorize HEALTHOLOGY EXPERTS, the doctors and those designated as assistants, to administer treatment as is deemed necessary to my son/daughter or minor.

_____

Patient Name

_____ _____

Parent/Legal Guardian Signature **Date**

ACKNOWLEDGMENT OF LIABILITY AND ASSIGNMENT OF BENEFITS

The undersigned patient and/or responsible party, herby acknowledge personal responsibility and liability for all medical services which are provided by HEALTHOLOGY EXPERTS, and all Doctors associated with it. This personal obligation is not affected by any obligation of insurance companies to pay health care costs. If an insurance company pays, the payments shall be credited to your account. If no insurance payment is received, you are completely responsible to pay for all medical treatments. In addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered, the undersigned hereby assigns the physician or facility named above the following rights, power, and authority.

REALEASE INFORMATION: You are authorized to release and to permit the examination or copying of any of my medical records, x-rays, laboratory reports, and the results of all tests of nay type or character to such person(s) as the physician and/or facility deems appropriate.

ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company or other person or entity to the extent of you bill for total services, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payments, and prosecute and receive penalties, interest, court costs, or other legally compensable amounts owed by an insurance company or other person or entity. I as the patient and/or responsible party, further agree to cooperate, provide information as needed and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request. The physician and/or facility is also assigned the exclusive, irrevocable right to request and receive for any insurance company or health care plan any information or supporting documentation concerning or touching upon the handling, calculation, processing, or payment of any claim.

DAMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above, you are hereby tendered demand to pay in full the bill for services rendered by the physician/facility named above, following your receipt of such bill for services to the extent such bills are payable under the terms of my/our policy for benefits, less any amount which I/we owe personally which are not payable under the terms of your policy.

THIRD PARTY LIABILTY: If patient(s) treatments for injuries are the result of the negligence of any third party, the patient(s) grant a secured interest (lien) against any recovery from such third part(s) to the extent of the bills for treatment in favor of the physician/facility named above.

STATUE OF LIMITATIONS: Patient(s) waive the right to claim any Statue of Limitations regarding claims for services rendered or to be rendered by the physician/facility named above.

TERMS AND ATTORNEY FEES: Net 30 days from date of invoice unless otherwise indicated. A finance charge of 1.5% per month (annual percentage rate of 18%) of the unpaid balance may be added monthly, both pre-judgement and post-judgement. Should collection become necessary, the patient(s) agrees to pay an additional 50% collection fee and all legal fees of collection, with or without suit, including attorney fees and court costs for services rendered by the physician/facility named above.

RETURNED CHECK DISCLAIMER: I/we agree to pay $25.00 returned check fee, attorney's fees of $150, all court, filing fees and charges or commissions of 50% that may be assessed to us by any collection agency retained to pursue this matter. I/we further agree to pay interest at the rate of 1.50% per month (18% per year).

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above power of attorney to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company, representing payment for treatment and healthcare rendered by physician/facility. Additionally, I grant the physician/facility the power of attorney to complete and sign any paperwork required to facilitate payment for care relative to injuries from a motor vehicle collision, i.e.: P.I.P. (Personal Injury Protection) application or other paperwork which may be required. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above. In the event that any provision of this Agreement is determined to be invalid or unenforceable, all other provisions of this Agreement shall remain enforceable.

A PHOTOCOPY OF THIS INTRUMENT SHALL SERVE AS ORGINAL
Signatures of Patients and Responsible Party:

_____

Print Patient Name

_____ _____

Signature of Patient or Parent/Legal Guardian **Date**

HIPAA

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present, and future physical or mental health condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients in our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include as Required by Law, Public Health Issues as Required by Law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration Requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation. Also, Research Criminal Activity, Military Activity, National Security, Workers' Compensation and Inmates, Required Uses and Disclosures. Under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent. Authorization or opportunity to object unless required by law.

You make revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use of disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copay the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of you protected health information, your protected health information will not be restricted. You then have the right to see another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternate means or at an alternate location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to receive an accounting of certain disclosures we have made, of any of your protect health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints:

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complain with us by notifying our private contact of your complaint. **We will not retaliate against you for filing a complaint.** This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and private practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at the main phone number.

Signature below is the only acknowledgement that you have received this Notice of our Privacy Policies.

Print Patient Name

Signature of Patient or Parent/Legal Guardian

Date