In-Line | CHIROPRACTIC
SAINTE GENEVIEVE

Chiropractic Informed Consent

SCOPE OF TREATMENT: Your treatment will primarily involve chiropractic procedures performed by Kelsie E. Hogenmiller, DC, Michelle L. Anthony, DC, and/or Kaitlyn P. Ayers, DC. Such chiropractic procedures may involve manual or mechanical manipulation of your joints and spine. The movement may cause an audible "popping" noise, like the sound made when you crack your knuckles. As part of your treatment, Kelsie E. Hogenmiller, DC, Michelle L. Anthony, DC, Kaitlyn P. Ayers, DC, or a staff member may also conduct spinal manipulative therapy, massage therapy, electrical stimulation, and other treatments. You must inform the doctor before treatment if you are pregnant, as such modalities may be hazardous to an unborn child.

RISKS: Chiropractic treatment does not guarantee certain results or promise to cure any ailments. Additionally, as with any health care treatment, chiropractic treatment involves certain complications or risks. These may include, but are not limited to, stiffness or soreness, muscle strain or spasms, aggravation or increase in symptoms, dislocations, fractures, and stroke. Please note that remaining untreated may also involve certain risks and may hinder the success of any future treatment.

Is it very common for patients to experience slight stiffness after treatment? More serious complications, such as fractures, are rare and generally result from an underlying bone weakness. The incidences of stroke are also exceedingly rare and have been estimated to occur between one in one million and one in five million adjustments.

Kelsie E. Hogenmiller, DC, Michelle L. Anthony, DC, and Kaitlyn P. Ayers, DC, will make every reasonable effort to minimize any risk of treatment; however, they may not be able to anticipate all potential complications. You are responsible for informing her if you have any condition or experience any symptoms that may not otherwise come to her attention.

CONSENT: I have read, or have had read to me, this informed consent. I have discussed it with Kelsie E Hogenmiller, DC, Michelle L. Anthony, DC, and/or Kaitlyn P. Ayers, DC, and have had the opportunity to ask questions about it. By signing below, I acknowledge that I agree to receive treatment, understand the risks involved, and consent to that treatment. I intend for this informed consent to cover the entire course of my treatment with In-Line Chiropractic, LLC, including any future conditions for which I may seek treatment. I wish to rely on Kelsie E. Hogenmiller, DC, Michelle L. Anthony, DC, and/or Kaitlyn P. Ayers, DC, to exercise her best judgment during my treatment to accomplish what she feels to by in my best interests.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMED CONSENT

_____ _____

Signature of Patient or Parent/Guardian Date

_____ _____

Printed name of patient Printed name of parent/guardian

_____ _____

Signature of Doctor of Chiropractic Date

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Patient Information

Date: _____

First Name: _____ MI: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone Number: _____ Social Security Number: _____

Email Address: _____

Date of Birth: _____ Age: _____ Gender (circle one): Male Female

Current medications, including frequency and dosage if known. If there are no medications, write "None".

_____

_____

_____

_____

_____

List any known allergies. If there are none, write "None".

_____

_____

_____

Briefly list your main health problems: (i.e., high blood pressure, diabetes, high cholesterol, diseases, cancers, major illnesses and/or injuries, etc.)

_____

_____

_____

Have you had an X-ray, CT scan, or MRI in the past 28 days? (circle one) Yes No

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Please circle any insurance coverage that may be applicable in this case.

Major Medical Worker's Compensation Medicaid Medicare Auto Accident Other

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to In-Line Chiropractic. I authorize the doctor to release all necessary information to communicate with my personal physicians, other healthcare providers, and payors, and to secure the payment of benefits. I understand that I am responsible for all costs associated with chiropractic care, regardless of my insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating physician, any fees for professional services will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

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Case History

Name: _____ Date: _____

1. What is your major symptom and its location? _____

_____

No Symptoms — Extreme Symptoms

0 5 10

2. If this is a recurrence, when was the first time you noticed the problem? _____

_____

3. How did it originally occur? _____ Date: _____

4. Has is become worse recently? Yes No Same Better Gradually Worse

   a. If yes, when and how? _____
   b. Number of days lost from work _____

5. Describe the pain (circle all that apply)

   Dull Sharp Sharp w/movement Throbbing Burning Deep Aching
   Tingling Stabbing Cramping , Numb Stiff Sore

6. Does the pain radiate outward from a central location? Yes No

7. What makes the problem worse? (circle all that apply)

   Sitting Standing Bending Over Lying down Lifting Twisting
   Other _____

8. Is there anything you can do to relieve the pain? Yes No
   If yes, describe _____

9. Have you had any broken bones? Yes No

   If yes, please list and give dates: _____

10. List any major accidents you have had: _____

_____

_____

11. What surgeries have you had? (include dates) _____

_____

12. Have you ever had chiropractic care before? Yes No
    If yes, when approximately was the last time you were treated? _____

    Previous Chiropractor _____

13. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
    Yes No Uncertain Weeks Gestation: _____

Patient Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

Doctor's Signature: _____ Date: _____

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Family History

Name: _____ Date: _____

Please review the below-listed diseases and conditions and indicate those that are health problems of a family member. Leave blank those spaces that do not apply.

Condition	Grandparent	Parent	Sibling	Children	Spouse
Aneurysm					
Arthritis					
Asthma- Hay Fever					
Back Trouble					
Bursitis					
Cancer					
Constipation					
Diabetes					
Disc Disease					
Headaches					
Heart Disease					
High Blood Pressure					
Insomnia					
Kidney Disease					
Liver Disease					
Lung Disease					
Migraines					
Nervousness					
Neuropathy					
Pinched Nerve					
Scoliosis					
Seizure					
Sinus Trouble					
Stomach Trouble					
Stroke					
Other:					

If any of the above family members are deceased, please list their age at death and cause: _____

_____

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information & Permission to Contact and Release of Information

Name_____ Date ____/____/____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal Law.

In order to improve communications between the office and our patients, we will be contacting you to confirm your appointment(s). Please ***check*** only (**1**) box below to indicate your preference for **appointment reminders** (* Message and Data rates may apply):

❑ **Voice** *(please provide phone # in the next section below)*

❑ *** Text** *if text, please **check** the box of your cell carrier & provide your phone # in the next section below:*

❑ AT&T	❑ Boost Mobile	❑ Cricket	❑ MetroPCS	❑ Nextel
❑ Sprint	❑ T-Mobile	❑ US Cellular	❑ Verizon	❑ Virgin Mobile

❑ *** Email** _____

Also, there may be times when we need to speak to you personally regarding your appointment or to discuss your **confidential health information**. Please provide how and where you would like to be contacted.
Please ***check*** the boxes below to indicate your preference.

Please contact me at: HOME# _____ **CELL#**_____ **WORK#**_____

❑ I authorize you to leave normal test results only on my voicemail.

❑ I request that you leave a message on my voicemail but only to indicate you have called, and I will return your call.

❑ **You may at any time release my confidential health information to: (if no one, please write NO ONE)**

Name	Relationship to Patient	Phone Type	Phone Number
Name	Relationship to Patient	Phone Type	Phone Number

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or other communications. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from the automated outreach and messaging system, when necessary.

Signature of Patient/Guardian/Parent Printed Name Date

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Financial Policy

Source of Payment: The Financial Policy of In-Line Chiropractic, LLC requires payment in full for all services rendered at the time of your visit, unless other arrangements have been made. The company generally accepts payment from the sources identified below. Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. We ask that you read and understand our policy as it applies to your situation. If you have questions related to your available sources of payment, please ask any staff member of In-Line Chiropractic.

Private Pay (No Insurance): If you do not have insurance or another party who may be responsible for paying for your health expenses, you are responsible for payment and must bring your amount current at each visit. We accept cash, check, or credit cards.

Time of Service Discount: For patients wishing to pay for all chiropractic services received at the time of service, a 30% discount will be applied. If you choose to utilize this service and have insurance benefits, In-Line Chiropractic will not be filing your insurance for you.

Group or Individual Insurance: The doctor(s) of In-Line Chiropractic are preferred provider(s) with most HMO's and PPO's. Please contact your HMO or PPO directly to discuss your benefits available to you, your responsibility for paying cost-sharing amounts, and any referral requirements.

Flex Plans/Medical Savings Accounts: Please inform In-Line Chiropractic if you have a medical savings account, sometimes known as a "flex plan". In-Line Chiropractic will be happy to provide you with a statement of your charges for reimbursement.

"On the Job" injury (Worker's Compensation): If you are injured on the job, your care may be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident. We do not deal with third party payors; therefore, you will be responsible for all amounts the time they are rendered and once case is settled, you can turn your itemized statement into your employer's Worker's compensation for re-imbursement directly to you.

Personal Injury or Automobile Accidents: Please notify your auto insurance carrier of your visit to In-Line Chiropractic immediately. Notify In-Line Chiropractic's insurance department immediately if an attorney is representing you. Once your treatment plan is completed, In-Line Chiropractic expects that you will notify your insurance carrier and inform them of your release from care. In-Line Chiropractic will wait for settlement of your claim after your care is completed up to 90 days. After 90 days, your credit card will be charged, and the insurance will pay you directly. You are required to have a credit card on file as a guarantee of payment. In-Line Chiropractic will charge your credit card if you are paid directly by the third-party payer and do not pay your bill by the statement date.

Medicare: In-Line Chiropractic accepts assignments from Medicare. Medicare ONLY covers medically necessary manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%. All other services In-Line Chiropractic provides are NON-COVERED. These services include, but are not limited to, examinations, therapies, and rehabilitation exercises. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. In-Line Chiropractic completes and files the forms for Medicare at no charge.

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Insurance: In-Line Chiropractic accepts assignment of insurance benefits in lieu of cash payments for certain services rendered to you. In-Line Chiropractic is willing to investigate the availability of insurance benefits, upon request. If so requested, you must provide accurate and up-to-date insurance information. Please be prepared to present your insurance identification card(s) at each visit. In-Line Chiropractic's communication with your insurance carrier is not a guarantee of payment. In-Line Chiropractic encourages you to contact your insurance carrier directly for detailed coverage information. In-Line Chiropractic will also assist you if you need help in filing claims with secondary insurance providers.

In-Line Chiropractic attempts to keep track of individual insurance plans and the amounts that they typically pay for procedures. However, plans routinely change, thus the estimated insurance payment may vary from your insurance carrier's actual payment. When your insurance payment is received, any necessary adjustments (credits or debits) will be made to your account.

It is important to remember that your insurance coverage is a contract between you, your employer (if applicable), and your insurance carrier. While In-Line Chiropractic will seek payment from your insurance provider before looking to you for payment, you are responsible for certain upfront fees. These may include, among other fees, co-payments, deductibles, and co-insurance amounts, as applicable. You will also be responsible for any amount that is not covered by insurance.

Payment Policy:

1. **Payment is due at the time of service, unless other arrangements have been made.**
2. **For your convenience, In-Line Chiropractic accepts cash, checks, Visa, MasterCard, Discover and American Express.**
3. **An insurance contract is between you, your employer, and your insurance carrier; therefore, it is your responsibility to keep the account current.**
4. **After 90 days, you will be billed and expected to make payment in full.**
5. **Patients involved in litigation (lawsuits) are responsible for payment for their services, as outlined above. In its discretion, In-Line Chiropractic may agree to wait for payment until the final disposition of your claims is reached, so long as you are an active patient. After 90 days, your credit card will be charged, and the insurance will pay you directly. You are required to have a credit card on file as a guarantee of payment.**
6. **Any fees for services rendered will be immediately due and payable if you suspend or terminate the care.**
7. **Any amount paid to In-Line Chiropractic relates to services only; x-rays, medical records, and other physical property will remain the permanent property of In-Line Chiropractic.**
8. **3 hours' notice is required when cancelling or rescheduling appointments. If no notice is given, or you do not show up at your appointment time, a $30 fee will be charged to your account.**
9. **If your check is returned due to insufficient funds, you will be assessed an insufficient fund fee of $30.**

Assignment and Authorization: I hereby assign to In-Line Chiropractic all medical and other benefits, including major medical benefits, related to the services provided to me by In-Line Chiropractic. I further authorize and direct my insurance carriers (including Medicare, private insurance, and any other health or medical plan) to issue payment directly to In-Line Chiropractic for services rendered to me and/or my dependents. I understand that I am responsible for any amount not covered by insurance. I also agree to pay In-Line Chiropractic any money that I receive from my insurance carrier for services provided to me for which I have not paid to In-Line Chiropractic.

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Financial Policy

I hereby authorize In-Line Chiropractic to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all my insurance submissions whether manual or electronic. Furthermore, I authorize the release of my medical records, including protected health information, to secure payment and/or to receive medical information pertaining to my case in In-Line Chiropractic's office.

If my account is delinquent, I agree to pay all expenses incurred by this office to collect the amount. This includes, but is not limited to, items such as 33% collection agency fees, court costs, and attorney fees.

My signature indicates my understanding and agreement with the policies stated above.

X_____ _____

Signature of Patient or Parent/Guardian | Date

_____ _____

Printed Name of Patient | Printed Name of Parent/Guardian (if minor patient)

The complete explanation of the financial policy is listed at the back of this packet for you to view before signing.

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NO CALL NO SHOW POLICY

If you need to cancel or reschedule your appointment, we respectfully request **at least 3 hours' notice.** Cancellations or missed appointments without notice will result in a **$30 fee**. If you are more than 10 minutes late for your appointment, you might be asked to reschedule, which will also result in a fee.

Thank you for your understanding!

Signature_____ Date_____