FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have, medical insurance, or you are self-pay, MVA/PI case, or workman compensation we are here to help you with the process. In order to achieve these goals, we need your assistance and your understanding of our financial policy.

Payment Plans for Chiropractic Services
To All Patients: Please initial next to your method of payment

_____ Cash/Private Pay Patient: To receive our discounted rate, payment is required at the time services unless prior arrangements have been discussed with staff member. A written copy of our fee schedule is available upon request.

_____ All New and Established Insurance Patients: To file your medical claims successfully, you must provide our office with updated insurance information. We do verify benefits; but only the co-pay, co-insurance and deductible information. Each insurance company provides a member number on back of the card for members to call and verify their own chiropractic benefits. You should also have knowledge of your co-pay, co-insurance if any, along with deductible information. We bill your insurance as a courtesy to you, with the understanding that you are ultimately responsible for your account in our office. All co-pays, and or co-insurances are due at the time of service. If we are unsure of what your copay or co-ins amount, you will be required to pay $40 per visit until the correct amount of your copay, or co-ins has been determined per your plan.

Please Note: Unless otherwise required by state law, benefits are subject to all contract limits and the member's status on the date of service, and not a guarantee of payment. Accumulated amounts, such as deductible, may change as additional claims are processed. Deductible and coinsurance are calculated from the member’s health allowances for the procedures performed when we verify your plan.

_____ Personal Injury/ MVA Patient: It is your responsibility to provide our office by the second visit with all personal injury insurance information; including PIP, third party, health insurance, adjuster name, attorney’s name, and letter of protection (LOP). We need all claim numbers and insured person’s name, address, and phone numbers. You are responsible for payment to our office for any services rendered. Fax LOP to Integrity Chiropractic Center, LLC 843-569-5973.

_____ Workman Compensation Patient or Disability Patient: You are responsible for providing our office with workman compensation information relating to your accident in the work place or disability determination. If your claim is not accepted, you will be responsible for your account balance.

__________________________________________  ________________
Patient (or Guardian) Signature                      Date

INTEGRITY CHIROPRACTIC CENTER, LLC
Patient Name

Integrity Chiropractic Center
Healing hands you can trust

DR. HUBERT A MURRAY
110A SPRINGHALL DR
GOOSE CREEK, SC
Office: 843-270-1288 Fax: 843-553-4436

NEW PATIENT INTAKE

Date: ________________

How did you hear about us? ____________________________

Reason for Visit: ____________________________ Symptoms Started ________________

Patient Demographics

First Name ____________________________ Middle Initial ___ Last Name ____________________________

Address ________________________________________________________________

City ____________________________ State ____________ Zip Code ____________

Home Phone (____) _______ - _______ Work Phone (____) _______ - _______

Cell Phone (____) _______ - _______ Email Address ____________________________

Date of Birth _____ / _____ / _____ Sex: Male Female

Social Security Number: _______ - _______ Marital Status: Single Married Other

Emergency Contact Information

Contact Name ____________________________ Relationship to Patient ____________________________

Contact Home Phone (____) _______ - _______ Cell Phone (____) _______ - _______

Insurance Information

Primary Insurance: __________________________________________ ID _______________________

Policy Holder’s Name: ____________________________ Group: # _______________________

Policy Holder’s Date of Birth _____ / _____ / _____ Primary Care Physician ____________________________

Secondary Insurance: __________________________________________ ID _______________________

Policy Holder’s Name: ____________________________ Group: # _______________________

Policy Holder’s Date of Birth _____ / _____ / _____ Primary Care Physician ____________________________

INTEGRITY CHIROPRACTIC CENTER, LLC
Please list all prescription medications you are taking including OTC, vitamins, and the amount taken:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>6</td>
</tr>
</tbody>
</table>

**Surgeries:** (Circle all that apply to you)
- Appendectomy
- Cardiovascular procedure
- Joint Replacement
- Prostate
- Brain
- Shoulder
- Carpal Tunnel
- Gastro-intestinal
- Other

**Allergies:** (Circle all that apply to you)
- Eggs
- Fish and Shellfish
- Soy
- Antibiotics
- Milk or Lactose
- Wheat/Glutens
- Peanuts
- Other

**Social History:** (Circle all that apply to you)
- Caffeine use: occasional
- Drink Alcohol: occasional
- Exercise: occasional
- Chew Tobacco: occasional
- Cigarettes: <1 pack/day
- Wear Seat Belts: occasional
- Other

**Family History:**
- Arthritis
- Cancer Type
- Diabetes
- Heart Disease
- Hypertension
- High Cholesterol
- Stroke
- Thyroid
- Other

**Please Circle:**
- Mother (Alive/Deceased)
- Father (Alive/Deceased)
- □ Mother □ Father □ Sister □ Brother □ Aunt □ Grandmother □ Grandfather
- □ Mother □ Father □ Sister □ Brother □ Aunt □ Grandmother □ Grandfather
- □ Mother □ Father □ Sister □ Brother □ Aunt □ Grandmother □ Grandfather
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- □ Mother □ Father □ Sister □ Brother □ Aunt □ Grandmother □ Grandfather
**Review of Systems** – (Check box if you have had trouble with any of the following, check NO if none)

<table>
<thead>
<tr>
<th>Cardiovascular</th>
<th>Respiratory</th>
<th>Allergic/Immunologic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past Present</td>
<td>Past Present</td>
<td>Past Present</td>
</tr>
<tr>
<td>Poor Circulation</td>
<td>Asthma</td>
<td>Hives</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Tuberculosis</td>
<td>Immune Disorder</td>
</tr>
<tr>
<td>Aortic Aneurism</td>
<td>Short Breath</td>
<td>HIV/AIDS</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>Emphysema</td>
<td>Allergy Shots</td>
</tr>
<tr>
<td>Heart Attack</td>
<td>Cold/Flu</td>
<td>Cortisone Use</td>
</tr>
<tr>
<td>Chest Pain</td>
<td>Cough</td>
<td></td>
</tr>
<tr>
<td>High Cholesterol</td>
<td>Wheezing</td>
<td>Ear, Nose and Throat</td>
</tr>
<tr>
<td>Pace Maker</td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>Jaw Pain</td>
<td></td>
<td>Difficulty Swallowing</td>
</tr>
<tr>
<td>Irregular Heartbeat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swelling of legs</td>
<td>Glaucoma</td>
<td>Dizziness</td>
</tr>
<tr>
<td></td>
<td>Double Vision</td>
<td>Hearing Loss</td>
</tr>
<tr>
<td>Genitourinary</td>
<td>No</td>
<td>Sore Throat</td>
</tr>
<tr>
<td>Past Present</td>
<td></td>
<td>Nosebleeds</td>
</tr>
<tr>
<td>Kidney Disease</td>
<td>Psychiatric</td>
<td>No</td>
</tr>
<tr>
<td>Burning Urination</td>
<td></td>
<td>Bleeding Gums</td>
</tr>
<tr>
<td>Frequent Urination</td>
<td></td>
<td>Sinus Infections</td>
</tr>
<tr>
<td>Blood in Urine</td>
<td>Anxiety</td>
<td>Gastrointestinal</td>
</tr>
<tr>
<td>Kidney Stones</td>
<td>Stress</td>
<td>No</td>
</tr>
<tr>
<td>Lower Side Pain</td>
<td>Gall Bladder Problems</td>
<td></td>
</tr>
<tr>
<td>Neurologic</td>
<td>Endocrine</td>
<td>Bowel Problems</td>
</tr>
<tr>
<td>Past Present</td>
<td>No</td>
<td>Constipation</td>
</tr>
<tr>
<td>Pinched Nerves</td>
<td>Hematologic</td>
<td></td>
</tr>
<tr>
<td>Parkinson’s</td>
<td>Thyroid</td>
<td>Liver Problems</td>
</tr>
<tr>
<td>Carpal Tunnel</td>
<td>Diabetes</td>
<td>Ulcers</td>
</tr>
<tr>
<td>Vertigo</td>
<td>Hair Loss</td>
<td>Diarrhea</td>
</tr>
<tr>
<td>Head Injury</td>
<td>Menopausal</td>
<td>Nausea/Vomiting</td>
</tr>
<tr>
<td>Brain Aneurysm</td>
<td>Menstrual</td>
<td>Bloody Stools</td>
</tr>
<tr>
<td>Numbness</td>
<td></td>
<td>Poor Appetite</td>
</tr>
<tr>
<td>Severe Headaches</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constitutional</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Past Present</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight Loss/Gain</td>
<td></td>
<td>Musculoskeletal</td>
</tr>
<tr>
<td>Low Energy Level</td>
<td></td>
<td>Past Present</td>
</tr>
<tr>
<td>Difficulty Sleeping</td>
<td></td>
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</table>

INTEGRITY CHIROPRACTIC CENTER, LLC
By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N = Numbness  B = Burning  S = Stabbing  T = Tingling  A = Dull Ache  ST = Stiffness  PN = Pain

How often do you experience your symptoms?
Constantly (76-100% of the day)  Frequently (51-75% of the day)  Occasionally (26-50% of the day)  Intermittently (0-25% of the day)

Please circle pain level that you are experiencing

| Neck Pain | 12345678910 |
| Upper Back | 12345678910 |
| Mid-Back | 12345678910 |
| Low Back | 12345678910 |
| Hip R/L | 12345678910 |
| Pelvic | 12345678910 |
| Leg R/L | 12345678910 |
| Arm or Shoulder R/L | 12345678910 |
| Other | 12345678910 |
AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Integrity Chiropractic Center may leave messages regarding appointment reminders, treatment, and/or other information pertinent to your healthcare and/or balances for healthcare provided. You have the right to request restrictions of use and disclosure of your health information. Please specify any restrictions and/or persons or parties you DO NOT authorize to receive protected health information (PHI).

Restrictions

Please list any persons you authorize Integrity Chiropractic Center to speak to in the event you are unavailable.

I authorize the following person(s) to receive all health information about appointments, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided at Integrity Chiropractic Center. Please know that your health information is important to us. The authorized person will need to show identification before information is released.

NAME_________________________________________________ RELATIONSHIP____________________________________

NAME_________________________________________________ RELATIONSHIP____________________________________

NAME_________________________________________________ RELATIONSHIP____________________________________

RIGHT TO TERMINATE OR REVOKE AUTHORIZATION: If you change your mind after authorizing use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before notification of your decision. You should contact Integrity Chiropractic Center LLC at 843-270-1288 or other authorization representative with any questions regarding this authorization.

POTENTIAL FOR RE-DISCLOSE: The person or organization to which health information is sent may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

EXPIRATION: This authorization is effective through 12/31/2020 unless revoked or terminated by the patient or patient’s personal representative.

PATIENT NAME (PLEASE PRINT)________________________________________________________

RESPONSIBLE PARTY NAME (IF OTHER THAN PATIENT)____________________________________

Signature__________________________________________________________

Relationship to patient______________________________________________
NOTICE OF PRIVACY PRACTICES

Integrity Chiropractic Center is committed to protecting your health information. This notice describes how medical information collected by Integrity Chiropractic Center may be used and disclosed. This notice describes your right as they relate to your protected health information and how you may access this information. Please review carefully. Protected Health Information (PHI) includes but is not limited to name, address, Social Security number, date of birth, treatment, diagnosis, history, and insurance information. We will use and/or disclose this information for daily healthcare operations, treatment, payment of services, appointment reminders, public health reporting, law enforcement, teaching and training. Any other disclosures not listed above will require your written consent. Psychological information will not be released under any circumstances. The request for this type of information must be made to the Psychologist with whom the notes originated. Protected Health Information shared by phone includes but is not limited to appointment confirmations, prescription notifications, balance due information, messages requesting a return phone call.

Patients have the right to:
- Request restrictions to Protected Health Information (must be in writing)
- Receive confidential communication (must be in writing)
- Inspect and copy Protected Health Information ($15.00 charge for copies)
- Amend or submit corrected information about Protected Health Information (must be in writing)
- Receive an accounting of disclosures and uses (1 free copy per year)
- Receive a paper copy of this notice

Law requires Integrity Chiropractic Center to maintain the privacy of Protected Health Information (PHI) and to provide this notice of legal duties and privacy practices. Integrity Chiropractic Center is required to abide by the terms of this notice and privacy practices. We are required to notify you if we are unable to agree with a request for restriction or amendments.

Concerns and complaints regarding privacy practices may be addressed:
Office for Civil Rights
US Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Integrity Chiropractic Center reserves the right to make changes to its notice and provisions by revising this document based on office policy changes and/or State and Federal Law requirements. You will be notified in writing of any changes at your next scheduled appointment.

I acknowledge that I have received and/or have been given the opportunity to review this Integrity Chiropractic Center LLC Office’s Notice of HIPAA Privacy Practices for protected health information.

Print Patient’s Name ___________________________________________ Date ____________

Patient’s Signature ___________________________________________ Date ____________

Consent to Treat a Minor: (Minor’s Printed Name) __________________________ Date ____________

INTEGRITY CHIROPRACTIC CENTER, LLC
Patient Name ________________________________

Guardian / Spouse's Signature Authorizing Care ________________________________ Date __________

Patient Waiver for Non-Covered Services OR No Chiropractic Benefits with Essential Health Insurance

Patient’s Name: ________________________________ Date: ________________________________

I believe that the following service(s), although it may not be covered by your health insurance, are an important part of your chiropractic care and I recommend that you receive these services as part of your current treatment plan. However, since the services listed here may not be a covered benefit under your current health plan, you should choose to receive these services; you will be personally responsible for the payment of such services. The purpose of this non-covered waiver notice is to help you make an informed choice about whether you want to receive these items or services.

☐ 97124 Massage therapy includes effleurage (circular movement), (lifting, squeezing), and/or (stroking, compression, percussion). $26 per 15 minutes Cash Price $20

☐ 97140 Manual therapy techniques include soft tissue and joint mobilization, manipulation, manual lymphatic drainage, manual traction, trigger point therapy (non-injectable), and myofascial release. $26 per 15 minutes Cash Price $20

☐ 97032 electrical stimulation-manual-each $30 per 15 minutes Cash Price $20

☐ 97012 Mechanical Traction $30 per 15 minutes Cash Price $20

☐ 97110 Therapeutic Exercise $30 per 15 minutes Cash Price $20

☐ 98943 5 Extraspinal Regions $30 flat fee Cash Price $20

☐ 97035 Ultrasound $30 per 15 minutes Cash Price $20

☐ Other Services ________________________________

Total Charges: __________

Reduces Charges ______

I acknowledge that I have been informed in advance of receiving these services, that these services may not be covered by my health insurance plan. I have chosen to receive these services at a reduced cost and understand that I will be financially responsible for the charges indicated above.

Please check below:

☐ I do not want the non-covered service needed for my treatment plan at a reduce cost
☐ I do want the non-covered services needed for my treatment plan at a reduce cost

Patient Name ________________________________ Date ________________________________ Please Print

INTEGRITY CHIROPRACTIC CENTER, LLC
INFORMED CONSENT

PATIENT NAME: ___________________________ DATE: ___________________________

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. In anything is unclear, please ask questions before you sign.

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible “pop” or “click,” much as you have experienced when you “crack” your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

- Spinal manipulative therapy
- Range of motion testing
- Muscle strength testing
- Ultrasound
- Radiographic studies
- Other (please explain)

- Palpation
- Orthopedic testing
- Postural analysis
- Hot/cold therapy
- Mechanical traction
- Vital signs
- Basic neurological testing
- Electrical Stimulation

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications that may arise during chiropractic manipulation and therapy. These complications include but are not limited to fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care, however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone that I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and painkillers
- Hospitalization
- Surgery
Patient Name__________________________

If you chose to use one of the above noted “other treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated
Remaining untreated may allow the formation of adhesions and reduce mobility that may set up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with (Dr. Hubert A Murray, DC) and have had my questions answered to my satisfaction. By signing below: I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended having been informed of the risks, I hereby give my consent to that treatment.

Dated:______________  Dated:______________

______________________________  ______________________________
Patient’s Name  Doctor’s Name

______________________________  ______________________________
Signature  Signature

______________________________
Signature of Parent or Guardian
(If a minor)