Comprehensive Chiropractic & Rehab

Date of Re-evaluation:_____

Name: _____ Date of birth: _____/_____/_____ SSN: _____ Date of accident: _____

Address: _____ City: _____ State: _____ Zip: _____ Attorney's Name: _____

Home Phone: _____ Cell: _____ Email: _____ Attorney's #: _____

GENERAL AND FINANCIAL POLICY

By signing below, you confirm that you have read this policy and understand that:

- It is your responsibility to inform our office staff of any address or telephone number changes.
- Your account is to be kept current. All self-pay or insurance copayments, co-insurance and deductibles will be collected at the time of service payable by cash, check, Visa, MasterCard, Discover, or American Express.
- If you do not have your payment (s), your appointment may be rescheduled.
- If you are unable to keep a scheduled appointment, please notify us 24 hours before your appointment so that we may offer that time to another patient. **There is a $40.00 charge for missing a scheduled appointment time, or giving less than 24 hours' notice, this includes massage appointments.**
- A return check will result in a $25.00 service charge and all future payments being required in the form of cash or credit card.
- There a $45.00 charge for the completion of paperwork (ex: disability, FMLA, etc)
- If your account is turned over to a collection agency, you will be responsible for any costs incurred in collection of said balance, which may include collection agency fees up to 35% of your outstanding balance, court costs and attorney fees.

IF YOU HAVE HEALTH INSURANCE COVERAGE: As a courtesy to you, our office will attempt to pre-verify your primary insurance coverage for your Chiropractic care. Coverage information is obtained from your insurance company using information provided by you prior to your initial visit. **We must emphasize that as medical providers at Comprehensive Chiropractic and Rehab, our relationship is with you, not your insurance company.** Please be advised that the information provided by your insurance company is not a guarantee of payment, only an estimate of what might be covered under your policy at the time of injury.

By signing below, you confirm you understand that:

- It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified.
- Not all services are a covered benefit with all insurance plans.
- It is your responsibility to be aware of what service (s) is being provided to you and if it is a covered benefit under your insurance.
- You are responsible for any non-covered charges not payable by your insurance policy.
- We will send all required claim forms and documentation to ensure your claims are processed in a timely manner.
- Final determination of benefits available is determined when the claim is sent to your insurance company and we receive an explanation of benefits from them.
- After all co-pays, contracted plan reductions and insurance payment credits are applied to your account, any remaining portion will be your responsibility.
- You are responsible for requesting a referral from your Primary Care doctor if your insurance policy requires one.
- If you are a **MEDICARE PATIENT,** please be advised that Medicare and Medicare Advantage Plans **only cover** Spinal Adjustments in a Chiropractor's office. All services outside of the Spinal Adjustment in our office will be your financial responsibility. As a patient, you are responsible for payment of the yearly Medicare deductible.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, *please* do not hesitate to ask us. **WE ARE HERE TO HELP YOU.**

I understand that services rendered by a licensed massage therapist in our office, are NOT reimbursed by insurances and that the office does not provide or fill out forms for insurance purposes. I agree I will be solely responsible for payment of these services at the time the service is provided.

By signing below, you have read and understand the above Financial Policy and agree to meet all financial obligations for services performed at Comprehensive Chiropractic and Rehab, Inc.

CONSENT TO TREATMENT: I hereby authorize and give consent for Dr Wai Wen "Michael" Cheng, and all associate staff to examine and treat me, this includes services that are covered by my health insurance policy and those that are not covered, it is my decision as a patient if I want to have those services performed at an out of pocket expense.

_____	X _____	_____
Printed Patient's Name	**Signature of Patient/Legal Guardian**	**Date**

CONSENT TO TREAT A MINOR: I hereby authorize and give consent for Dr Wai Wen "Michael" Cheng, and all associate staff to examine and treat my child appropriately, this includes services that are covered by my health insurance policy and those that are not covered, and if needed, treat my minor child _____ (child's name).

_____	_____	_____
Printed Name Legal Guardian	**Signature of Legal Guardian**	**Date**

REVISED: 6/11/2018; 9/9/2020; 10/18/2020; 5/18/2023

Comprehensive Chiropractic & Rehab™

NOTICE OF PRIVACY PRACTICES

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We use your Patient Health Information We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacies who are filling your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payment from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses
We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that me be of interest to you.

Other Uses and Disclosures
We may use or disclose identifiable health information about you for other reasons, even without your consent.
Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Research: We may use or disclose information for approved medical research.
Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena or court order.
Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.
Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, organ donation agencies.
Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health safety of the public or another person.
Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illnesses.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any further uses and disclosures.

Individual Rights
You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.
Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.
Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using post cards to remind you of appointments.
Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.
Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.
Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment or health care operations.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices
We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting are and in each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Suman Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, please contact:

Comprehensive Chiropractic and Rehab, Inc
Attn: Office Manager
1422 Easton Road
Abington, PA 19001
215-443-5626

Effective Date: April 14, 2003

I, _____
hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed:X
_____

Date: _____

Acknowledgment from Parent or Guardian of a minor (under the age of 18)

Parent/Guardian's Name:
_____

Signature:X
_____

Date: _____

Comprehensive Chiropractic & Rehab™

Appointment Cancellation Policy

At Comprehensive Chiropractic and Rehab we are continuously updating and improving our policies to provide our patients with services suited to fit your needs. Our Appointment Cancellation Policy has been revised and this signed acknowledgement will supersede all previous policies.

A cancellation made with less than 24 hours' notice significantly limits our ability to make the appointment available for another patient in need.

Cancellation/ No-Call, No-Show, Late Policies for ALL Patients

- Please provide our office with 24-hour notice when cancelling or rescheduling an appointment. This will allow us the opportunity to provide care to another patient. A message can always be left on our voicemail, or an email can be sent to avoid a cancellation fee being charged to your account.
- ***A "No-Call", "No-Show" or missed appointment, without proper 24-hour notification, will be assessed a $50 fee.***
- This fee is not billable to your insurance.
- A 10-min grace period will be allowed for late arrivals only. After 10 minutes the appointment is considered a NoCall, No-Show and the $50 fee will apply.
- As a courtesy, we offer automated reminder calls, emails, and text massages for all appointments, beginning 7 days in advance. If you have opted out from receiving a reminder notification, this cancellation policy still applies.
- Repeated "No-Show", "No-Call" or missed appointments may result in termination of the physician/patient relationship.

Massage Policies

- ***In addition to the above terms***, the following items apply to massage services.
- If you cancel an appointment for massage services a total of 3 times, you will be required to pay the full price of the massage in place of the deposit amount when you schedule.
- If you are late for a massage appointment, the massage can still be provided minus the amount of time you missed.
- Please be sure to arrive 5-10 min prior to the appointment time to allow enough time to undress and be ready for the therapy to begin at the scheduled time.
- **Utilizing Insurance Plans:** In some circumstances your health insurance policy may cover massage therapy in our office. To utilize this portion of your policy, you **MUST** be under chiropractic care with the doctor. The above fees for cancellations still apply.
- **Utilizing Packages:** If you purchase a gift package for massage services, you will not be required to leave a deposit for a scheduled appointment. If you do cancel without 24-hour notice, the $50 fee will be deducted from the balance of your package.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have. A copy of this policy will be provided to you. Please sign and date below your acknowledgement.
I have read and understand the Appointment Cancellation Policy and I acknowledge its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

Patient's Name: _____ Signature:_____ Date: _____

Comprehensive Chiropractic & Rehab™

MOTOR VEHICLE ACCIDENT QUESTIONAIRE

Name: _____ Date of Accident: _____ Time: _____ AM / PM

Intersection: _____ **City**: _____ **State**: _____

Police/EMT: □ YES □ NO **Police Dept:** _____ **Was a report made?** : □ YES □ NO

Weather conditions: _____

Hospital ER Visit: □ YES □ NO **Where:** _____ **When**: □ IMMEDIATELY □ NEXT DAY □ _____

Role during the accident: □ DRIVER □ PASSENGER (□ FRONTSEAT □ BACKSEAT) □ PEDESTRAIN

Describe the vehicle you were in: Make: _____ Model: _____ Year: _____

□ Small-sized car □ Mid-sized car □ Large-sized car □ 2-Door vehicle □ 4 Door-vehicle

□ Pick-up truck □ Sports Utility Vehicle □ Mini-van or Cargo Van □ Large truck, bus, semi-truck

What type of vehicle was the car involved? _____

How fast was the vehicle you were in going: _____mph **Other vehicle: _____mph**

At the time of the accident, how were you facing? □ STRAIGH AHEAD □ RIGHT □ LEFT □ DOWN □ UP

Did you wear a seatbelt? □ YES □ NO **Were your brakes applied?** □ YES □ NO **Did the airbags deploy?** □ YES □ NO

Did you brace yourself for the impact? □ YES □ NO

Where was the impact on the car? □ FRONT □ REAR □ LEFT SIDE □ RIGHT SIDE

Were you shoved at the time of impact? □ YES □ NO **If yes**, □ FORWARD □ BACKWARD □ SIDEWAYS

What part of your body hit the interior of the vehicle? _____

What part of the vehicle did your body hit? _____

Is your vehicle totaled? □ YES □ NO **If no, how much damage occurred?** _____

After the accident, where you: □ CONSCIOUS □ UNCONSCIOUS □ DAZED □ CONFUSED

What did you feel or experience at that time? _____

Were you shocked or surprised when the accident occurred? □ Yes □ No

Describe what happened: _____

_____

_____

Have you had treatment since the accident? □ YES □ NO **If yes, with who?** _____

Current Complaints: _____

_____

_____

Rating of your pain when its at the worse: 0 1 2 3 4 5 6 7 8 9 10

Current medications? _____

Allergies? □ YES □ NO **If yes, please list them** _____

Patient's Signature:_____ **Date:** _____

Doctor's Signature: _____ **Date:** _____

Comprehensive Chiropractic & Rehab™

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION/MEDICAL RECORDS

Authorization for Use/Disclosure of Information: I_____voluntarily consent to authorize **Comprehensive Chiropractic & Rehab, Inc (Comprehensive Chiropractic or CCR)** to use and/or disclose my health information and medical records during the term of this Authorization to the practice that I have identified below as the law firm representing a motor vehicle accident case that I was involved in. Date of Loss: _____.

Recipient: *I authorize my medical and health records to be released to:*

Law Firm/Legal Representation: _____

Address: _____

Phone: _____ Fax: _____

Purpose: *I authorize my records to be released to provide documentation of treatment I received, that can potentially be used in a court setting or legal conference regarding the injuries I sustained from the above noted motor vehicle accident.*

Information to be disclosed: *I authorize the release of the following health information: (check all that apply below):*

- ❑ All treatment, therapy and healthcare records pertaining to services received and rendered at Comprehensive Chiropractic as ordered, prescribed, and/or administered by Dr. Wai-Wen (Michael) Cheng, DC and staff representing his practice.
- ❑ These records include treatment status and prognosis, progress notes, reports and testing results ordered by Dr. Wai-Wen Cheng, a list of scheduled and attended appointments, all billing/claims generated and submitted for services rendered and received.
- ❑ All payment details for claims submitted by Comprehensive Chiropractic to _____, known as the automobile insurance company in which I am covered through and provides "Personal Injury Protection" benefits (referred to as PIP coverage) on my policy.
- ❑ All payment details for claims submitted by Comprehensive Chiropractic to _____, known as the health insurance company in which I am covered through and provides medical coverage and health benefits. This policy information was provided as secondary coverage in case the "PIP" benefits and claim coverage exhaust prior to completion of treatment.
- ❑ All out of pocket cost that the health insurance company which my medical policy is through, will be collected at the time of service (this includes co-pays, deductibles and co-insurance); for which is listed as the patient responsibility, are to be included in final billing report(s) from claims processed through the secondary coverage I provided as a backup for billing purposes.

Term: *Until all court related proceedings are completed regarding the case for which representation was retained.*

Redisclosure: *I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.*

Refusal to sign/right to revoke: *I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment. I understand I can revoke this Authorization by notifying the office.*

Questions: *Contact Comprehensive Chiropractic & Rehab, Inc at 1422 Easton Road, Attn: Office Manager, Abington PA 19001 or 215-443-5626.*

_____ _____ _____

Signature Date Signature of Witness

If Individual is unable to sign this Authorization, please complete the information below:

_____ _____ _____ _____

Name of Guardian/Representative Legal Relationship Date Witness

Comprehensive Chiropractic & Rehab™

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION/MEDICAL RECORDS

Authorization for Use/Disclosure of Information: I _____voluntarily consent to authorize

(Name of Hospital or Urgent Care Center)

_____

to use or disclose my health information/medical records during the term of this Authorization to the recipient that I have identified below.

Recipient: I authorize my health care information to be released to the following recipient:

Name:_____**COMPREHENSIVE CHIROPRACTIC & REHAB, INC** _____

Address:_**1422 EASTON ROAD, ABINGTON PA 19001**_____ Phone:__**215-443-5626**__ Fax:__**215-443-5973**__

Purpose: I authorize the release of my health information for the following specific purpose: **continuity of care.**

Information to be disclosed: I authorize the release of the following health information: (check one box below)

- ☐ All of my health information that my provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.

- ☑ Only the following records or types of health information:
  Emergency Department or Urgent Care Center visit records following a MVA on _____, and all radiology reports (including MRI's, X-rays, and CT Scans)

Term: I understand that this Authorization will remain in effect:

- ☐ From the date of this Authorization until the _____ day of _____, 20___.
- ☑ Until the Provider fulfills this request.
- ☐ Until the following event occurs:_____

Rediscloure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at CCR. If I change my mind, I understand that I can revoke this Authorization by providing a written notice of revocation to Comprehensive Chiropractic & Rehab, Inc at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Questions: I may contact Comprehensive Chiropractic & Rehab, Inc for answers to my questions about the privacy of my health information at 1422 Easton Road, Attn: Office Manager, Abington PA 19001, or by telephone at 215-443-5626.

✕_____	_____	_____
Signature	Date	Signature of Witness

If Individual is unable to sign this Authorization, please complete the information below:

_____	_____	_____	_____
Name of Guardian/ Representative	Legal Relationship	Date	Witness

REVISED: 6/11/2018 ; 5/18/2023