Fairfield Spine and Rehab Center, LLC

James S. DePietro, DC, DIANM
Diplomate International Academy of Neuromusculoskeletal Medicine

Informed Consent for Telemedicine Services

Patient Name:_____ Location of Patient:_____	DOB: ___/___/___	Account#:_____
Physician Name:_____ Location:_____		Date:_____/_____/20____

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to James S. DePietro, DC providing health care services to me via telemedicine.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit.

I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting James S. DePietro, DC at Fairfield Spine and Rehab Center (740) 654-3375. As long as this consent is in force (has not been revoked/withdrawn) James S. Depietro, DC may provide health care services to me via telemedicine without the need for me to sign another consent form.

X _____ X ____/____/20___
Signature of Patient/Legal Guardian Date

_____
Relationship to patient if authorized signer

X _____ X ____/____/20___
Witness Date

I have been offered a copy of this consent form (patient's initials)_____

2217 West Fair Ave.
Lancaster, OH 43130
740-654-3375, Fax 740-654-3985
www.rehabmyspine.com

Account # _____

Date: _____

Application For Care

Patient Questionnaire

(The answers below will be part of your electronic file and are required by the US Government)

Legal Name: First_____Middle_____Last_____

Date of Birth_____ Social Security No. _____-_____-_____

Preferred method of contact **(for private messages)**: ☐ E-mail ☐ Home Phone ☐ Mail ☐ Cell Phone

Home Phone_____ Cell_____ E-mail_____

Address: Street_____

City_____State_____Zip_____

Marital Status: ☐ Married, Name of Spouse_____ ☐ Single ☐ Divorced ☐ Separated

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male/Trans Man/Female-to-Male ☐ Transgender Female/Trans Woman/Male-to-Female ☐ Genderqueer, neither exclusively Male nor Female ☐ Additional gender category or other (please specify) ☐ Decline to specify

Sexual orientation: ☐ Straight or heterosexual ☐ Lesbian, gay, or homosexual ☐ Bisexual ☐ Something else, please describe _____ ☐ Decline to specify ☐ Don't know

Ethnicity/Race: ☐ White or Caucasian ☐ Hispanic or Latino ☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander ☐ Black or African American ☐ Asian ☐ Other_____

Preferred Language: ☐ English ☐ Spanish ☐ German ☐ Other_____

Family Doctor_____ Referral Doctor_____

Insurance

☐ Self Pay ☐ Medicare/MediGold ☐General Insurance ☐ Workers Comp. ☐ Personal Injury

Insurance Company_____ Group_____

ID Number_____ Are you the primary card holder? ☐ Yes ☐ No

Insured Name:_____ Date of birth_____

Secondary insurance: ☐ Yes ☐ No Name_____

Account # _____

Name:_____ Date: _____ DOB: _____/_____/_____

Current height: _____ Current weight: _____

Complaints

1. Please describe your primary complaint: _____
2. When did your primary problem start? _____
3. What caused your primary problem (e.g. injury, lifting.)? _____
   _____
4. Do you have any other secondary complaints? □ No □ Yes Please explain: _____
   _____

Please rate your symptoms on a scale from 0-10 where 0 is no pain and 10 is unbearable pain.

(please rate the pain at the current moment even if it fluctuates)

Example: Area: Lower back - 7/10

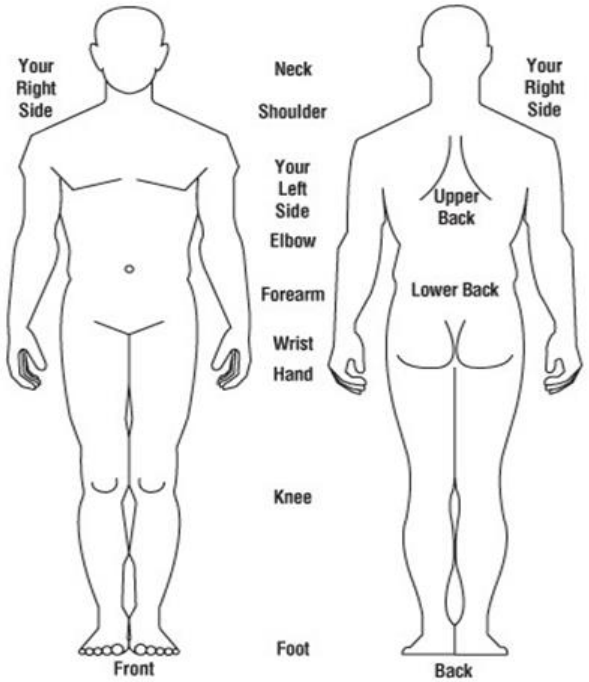
Area: _____ - _____/10 Area: _____ - _____/10

Area: _____ - _____/10 Area: _____ - _____/10

Area: _____ - _____/10 Area: _____ - _____/10

Please use the symbols below to draw on the body where you feel your symptoms.

A=Ache B=Burning N=Numbness T=Tingle P= Pins/Needles o=Other _____



Account#_____

Name:_____ Date: _____ DOB: _____/_____/_____

5. How often is your pain present? Write your complaints next to the frequency that fits the best.
   Constant (present 76-100%)_____
   Frequent (present 51-75%)_____
   Occasional (present 26-50%)_____
   Intermittent (present 0-25%)_____

6. Does your pain radiate to your arms or legs? ☐ No ☐ Yes If yes, where?_____

7. What time of day is your pain its worst? ☐ AM ☐ Afternoon ☐ PM
8. What position(s) or activities increase your pain?_____
   _____
9. What position(s) or activities decrease your pain?_____
   _____
10. Are you taking any prescription or over the counter medication for your complaints? ☐ No ☐ Yes. If yes what meds? _____
11. What home treatment have you tried (eg, ice, heat, exercises) for your condition? _____
    _____
12. Is your condition worse with coughing, sneezing or straining with bowel movements? ☐ No ☐ Yes (explain): _____
13. Are you losing control of bladder or bowel function? ☐ No ☐ Yes (if yes please explain: _____
    _____
14. Any recent illness? ☐ No ☐ Yes explain: _____
15. Do you suffer from severe fatigue? ☐ No ☐ yes (explain):_____
16. Have you suffered weight loss of over 10 pounds without trying? ☐ No ☐ Yes
17. Do you suffer from chills or night sweats? ☐ No ☐ Yes
18. Have you seen any other health care providers for your problem(s)? ☐ No ☐ Yes
    If yes, who? _____
    Treatment?_____
19. What are you here for? ☐ Pain relief ☐ Pain relief and corrective care
20. Have you ever had chiropractic care in the past? ☐ No ☐ Yes (if yes when was last treatment) _____

Patient (or legal guardian) signature X_____ Date X_____

Functional Rating Index

For use with Neck and/or Back Problems

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item, please **circle** the number which most closely describes your condition right now.

1. **Pain Intensity**

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. **Sleeping**

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. **Personal Care (washing, dressing, etc.)**

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. **Travel (driving, etc.)**

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. **Work**

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. **Recreation**

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. **Frequency of pain**

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. **Lifting**

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. **Walking**

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking

10. **Standing**

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

Signature X _____ Date X _____ Total Score: _____

Name: _____(Printed) Account#_____

Account#_____

Name:_____ Date: _____ DOB: _____/_____/_____

Surgery/Hospitalizations

□ I have not had any surgeries, nor have I ever been in the hospital.

Please list surgeries and the year performed and hospitalizations and the reason**. Example: Left knee scope Jan/2011 or Hospitalized for 6 days July 2004 for heart attack (Use separate sheet of paper if necessary)**

_____

_____

_____

Medications

□ I have provided an updated list of medications/vitamins to the receptionist.(no need to fill out below)

Please include prescription, over the counter medication and supplements/vitamins/herbs, etc. If you have an update list of medications please provide that to the front desk so a copy can be made. Here are my medications with doses and date started: (Include amount of pills, strength and times per day you take)

_ **Example: aspirin 81mg 1/day started April 2006**___ / _____

_____ / _____

_____ / _____

_____ / _____

Allergies

□ I have no known allergies to medications, foods, or environmental objects.

Please list allergies to medications, environmental, and food objects. Please give a brief description of the allergic reaction, when it started (year) and severity. **Example: Penicillin-Feb 2006, skin rash-mild**

_____ / _____

_____ / _____

_____ / _____

Past Medical History

(Check all that apply)

	Anemia		Blood Clots		Gallbladder		Heart Attack
	Angina		Cancer		GERD		Osteoarthritis
	Anxiety		Stroke		Hepatitis C		Osteoporosis
	Gout		COPD		High Cholesterol		Fainting
	Asthma		Coronary Disease		High Blood Pressure		Rheumatoid Arthritis
	Atrial Fibrillation		Crohn's Disease		Irritable Bowel		Dizziness
	Prostate Disease		Depression		Liver Disease		Neck pain
	Kidney Disease		Diabetes		Migraines		Headaches
	Seizures		Thyroid Disease		Peptic Ulcer		Other:

Account#_____

Name:_____ Date: _____ DOB: _____/_____/_____

Review of Systems

(Check all that apply)

	Night sweats		Impotence
	Lack of energy		Pain in joints
	Unexplained weight loss or gain		Swelling in joints:
	Facial pain or numbness		Rashes
	Nose bleeds		Skin lesions
	Nasal drip		Hair loss/increase
	Mouth sores		Double vision
	Irregular heart beat		Poor balance
	Chest pains		Visual loss
	Swollen legs or feet		Tremors
	Pain in legs with walking		Headaches
	Shortness of breath		Anxiety
	Prolonged cough		Depression
	Coughing up blood		Intolerance to heat/cold
	Heart burn		Menstrual problems
	Constipation		Easy Bruising
	Diarrhea		Frequent thirst
	Incontinence		Easy bleeding
	Painful or frequent urination		Blood diseases
	Prostate problems		Seasonal allergies
	Change in sex drive/energy level		Infections
	Anemia		Other:

Family History

(Please check and **identify the family member** who has/had the condition)

	Cancer:		Heart Disease:
	Stroke:		Diabetes:
	Cystic Fibrosis:		Back Problems:
	Rheumatoid Arthritis:		High Blood Pressure:
	Migraines:		Skin Lesions:
	Lupus:		Other:

Implantable Devices

☐ I have no implanted devices ☐ I have a _____implanted.

Social History

Number of children_____ Alcohol usage: drinks per day? _____ Caffeinated beverages per day? _____
Tobacco usage: ☐ Never or _____ packs/day for _____ years. Date quit _____ (year)
Advanced Directive: ☐ Yes ☐ No ☐ I do not know Do you use illegal drugs? ☐ Yes ☐ No
Employer_____ Job Title_____
☐ Retired ☐ Unemployed ☐ Permanently Disabled, If yes, when _____
Level of Education_____

I have read the information provided and answered the questions truthfully to the best of my knowledge, and hereby authorize this office to provide a chiropractic exam and if agreed on care, in accordance with this state's statues.

Patient or Legal Guardian signature X_____ Date X_____

Fairfield Spine and Rehab Center, LLC

James S. DePietro, DC, DIANM
Diplomate International Academy of Neuromusculoskeletal Medicine

Notice of Privacy Practices

Effective December 27, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

The Practice (the "Practice"), in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, (the "Privacy Rule") and applicable state law, is committed to protecting the privacy of your protected health information ("PHI"). PHI includes information about your health condition and the care and treatment you receive from the Practice. The Practice understands that information about your health is personal. This Notice explains how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The Practice is required by law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and practices with respect to your PHI. The Practice is obligated to notify you promptly if a breach occurs that may have compromised the privacy and security of your PHI. The Practice is also required by law to abide by the terms of this Notice.

HOW THE PRACTICE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The Practice, in accordance with this Notice and without asking for your express consent or authorization, may use and disclose your PHI for the purposes of:

For Treatment – We may use your PHI to provide you with treatment. We may disclose your PHI to doctors, nurses, technicians, clinicians, medical students, hospitals and other health facilities involved in or consulting in your care. We may also disclose information about you to people outside the practice, such as other health care providers involved in providing treatment to you, and to people who may be involved in your care, such as family members, clergy, or others we use to provide services that are part of your care. If we refer you to another health care provider, we would, as part of the referral process share PHI information about you. For example, if you were referred to a specialist, we would contact the doctor's office and provide such information about you to them so that they could provide services to you.

For Payment – We may use and disclose your PHI so we can be paid for the services we provide to you. For example, we may need to give your insurance company information about the health care services we provided to you so your insurance company will pay us for those services or reimburse you for amounts you have paid. We also may need to provide your insurance company or a government program, such as Medicare or Medicaid, with information about your condition and the health care you need to receive prior approval or to determine whether your plan will cover the services.

For Health Care Operations – We may use and disclose your PHI for our own health care operations and the operations of other individuals or organizations involved in providing your care. This is necessary for us to operate and to make sure that our patients receive quality health care. For example, we may use information about you to review the services we provide and the performance of our employees in caring for you.

OTHER USE & DISCLOSURES THAT ARE REQUIRED OR PERMITTED BY LAW

The Practice may also use and disclose your PHI without your consent or authorization in the following instances:

Appointment Reminders -We may use and disclose your PHI to remind you by telephone or mail about appointments you have with us, annual exams, or to follow up on missed or cancelled appointments.

Individuals Involved in Your Care or Payment for Your Care – We may disclose to a family member, other relative, a close friend, or any other person identified by you certain limited PHI that is directly related to that person's involvement with your care or payment for your care. We may use or disclose your PHI to notify those persons of your location or general condition. This includes in the event of your death unless you have specifically instructed us otherwise. If you are unable to specifically agree or object, we may use our best judgment when communicating with your family and others.

Disaster Relief - We also may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts. This will be done to coordinate information with those organizations in notifying a family member, other relative, close friend or other individual of your location and general condition.

De-identified Information – The Practice may use and disclose health information that may be related to your care but does not identify you and cannot be used to identify you.

Business Associate – The Practice may use and disclose PHI to one or more of its business associates if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies.

Personal Representative – The Practice may use and disclose PHI to a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

Emergency Situations – The Practice may use and disclose PHI for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible: The Practice may also use and disclose PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

Public Health and Safety Activities – The Practice may disclose your PHI about you for public health activities and purposes. This includes reporting information to a public health authority that is authorized by law to collect or receive the information. These activities generally include:

- To prevent or control disease, injury or disability
- To report births or deaths
- To report child, elder, or dependent adult abuse or neglect
- To report reactions to medications or problems with products
- To notify people of recalls of products they may be using
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence – We may disclose your PHI to a government authority authorized by law to receive reports of abuse, neglect, or domestic violence, if we believe an adult or child is a victim of abuse, neglect, or domestic violence. This will occur to the extent the disclosure is (a) required by law, (b) agreed to by you, (c) authorized by law and we believe the disclosure is necessary to prevent serious harm, or, (d) if you are incapacitated and certain other conditions are met, a law enforcement or other public official represents that immediate enforcement activity depends on the disclosure.

Health Oversight Activities – We may disclose your PHI to a health oversight agency for activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions. These and similar types of activities are necessary for appropriate oversight agencies to monitor the nation's health care system, government benefit programs, and for the enforcement of civil rights laws.

Judicial and Administrative Proceedings – We may disclose your PHI in response to a court or administrative order. We also may disclose information about you in response to a subpoena, discovery request, or other legal process but only if efforts have been made to tell you about the request or to obtain an order protecting the information to be disclosed.

Disclosures for Law Enforcement Purposes – We may disclose your PHI to law enforcement officials for these purposes:

- As required by law
- In response to a court, grand jury or administrative order, warrant or subpoena
- To identify or locate a suspect, fugitive, material witness or missing person
- About an actual or suspected victim of a crime if, under certain limited circumstances, we are unable to obtain that person's agreement
- To alert a potential victim or victims or intending harm ("duty to warn")
- To alert law enforcement officials to a death if we suspect the death may have resulted from criminal conduct
- About crimes that occur at our facilities
- To report a crime, a victim of a crime or a person who committed a crime in emergency circumstances

To Avert Serious Threat to Health or Safety – We will use and disclose your PHI when we have a "duty to report" under state or federal law because we believe that it is necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to help prevent a threat.

Coroners, Medical Examiners and Funeral Directors – We may disclose your PHI to a coroner or medical examiner for purposes such as identifying a deceased person and determining cause of death. We also may disclose information to funeral directors so they can carry out their duties.

Organ, Eye or Tissue Donation – To facilitate organ, eye or tissue donation and transplantation, we may disclose your PHI to organizations that handle organ procurement, banking or transplantation.

Workers Compensation – We may disclose your PHI to the extent necessary to comply with worker's compensation and similar laws that provide benefits for work-related injuries or illness without regard to fault.

Special Government Functions – If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release information about foreign military authority. We may disclose information about you to authorized federal officials for intelligence, counter-intelligence and other national security activities authorized by law.

Research – We may use and/or disclose your PHI for research projects that are subject to a special review process. If researchers are allowed access to information that information that identifies who you are, we will ask for your permission.

Fundraising – We may contact you with respect to fundraising campaigns. If you do not wish to be contacted for fundraising campaigns, please notify our Privacy Officer in writing.

AUTHORIZATION

The following uses and/or disclosures specifically require your express written permission:

Marketing Purposes – We will not use or disclose your PHI for marketing purposes for which we have accepted payment without your express written permission. However, we may contact you with information about products, services or treatment alternatives directly related to your treatment and care.

Sale of Health Information – We will not sell your PHI without your written authorization. If you do authorize such a sale, the authorization will disclose that we will receive compensation for the information that you have authorized us to sell. You have the right to revoke the authorization at any time, which will halt any future sale.

Uses and/or disclosures other than those described in this Notice will be made only with your written authorization. If you do authorize a use and/or disclosure, you have the right to revoke that authorization at any time by submitting a revocation in writing to our Privacy Officer. However, revocation cannot be retroactive and will only impact uses and/or disclosures after the date of revocation.

YOUR RIGHTS

Right to Revoke Authorization – You have the right to revoke any Authorization or consent you have given to the Practice, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

Right to Request Restrictions – You have the right to request that we restrict the uses or disclosures of your information for treatment, payment or healthcare operations. You may also request that we limit the information we share about you with a relative or friend of yours. You also have the right to restrict disclosure of information to your commercial health insurance plan regarding services or products that you paid for in full, out-of-pocket, and we will abide by that request unless we are legally obligated to do otherwise.

We are not required to agree to any other requested restriction. If we agree, we will follow your request unless the information is needed to a) give you emergency treatment, b) report to the Department of Health and Human Services, or c) the disclosure is described in the "Uses and Disclosures That Are Required or Permitted by Law" section. To request a restriction, you must provide your request in writing to the Practice's Privacy Officer. You must tell us: a) what information you want to limit, b) whether you want to limit use or disclosure or both, and c) to whom you want the limits to apply. Either you or we can terminate restrictions at a later date.

Right to Receive Confidential Communications – You have the right to request that we communicate your PHI in a certain way or at a certain place. For example, you can ask that we only contact you by mail or at work.

If you want to request confidential communications you must do so in writing to our Practice's Privacy Officer and explain how or where you can be contacted. You do not need to give us a reason for your request. We will accommodate all reasonable requests.

Right to Inspect and Copy – You have the right to inspect and request copies of your information.

To inspect or copy your information, you may either complete an Authorization to Release/Obtain Information form or write a letter of request, stating the type of information to be released, the date(s) of service being requested, the purpose of the request, and whether you wish to review the record or receive copies of the requested information in your preferred format. We will abide by your request in the format you have requested, if we are able to do so. If we cannot provide your records to you in the requested format, we will attempt to provide them in an alternative format that you agree to. You may also request that your records be sent to another person that you have designated in writing. Direct this request to the Practice's Privacy Officer. You may be charged a fee for the cost of copying, mailing or other expenses related with your request.

We may deny your request to inspect and copy information in a few limited situations. If you request is denied, you may ask for our decision to be reviewed. The Practice will choose a licensed health care professional to review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of that review.

Right to Amend – If you feel that your PHI is incorrect, you have the right to ask us to amend it, for as long as the information is maintained by us. To request an amendment, you must submit your request in writing to the Practice's Privacy Officer. You must provide a reason for the amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason for wanting the amendment. We also may deny your request if the information: a) was not created by us, unless the person or entity that created the information is no longer available to amend the information, b) is not part of the information maintained by the Practice, c) is not information that you would be permitted to inspect and copy or d) is accurate and complete.

If your request is granted the Practice will make the appropriate changes and inform you and others, as needed or required. If we deny your request, we will explain the denial in writing to you and explain any further steps you may wish to take.

Right to an Accounting of Disclosures – You have the right to request an accounting of disclosures. This is a list of certain disclosures we have made regarding your PHI. To request an accounting of disclosures, you must write to the Practice's Privacy Officer. Your request must state a time period for the disclosures. The time period may be for up to six years prior to the date on which you request the list, but may not include disclosures made before April 14, 2003.

There is no charge for the first list we provide to you in any 12-month period. For additional lists, we may charge you for the cost of providing the list. If there will be a charge, we will notify you of the cost in advance. You may withdraw or change your request to avoid or reduce the fee.

Certain types of disclosures are not included in such an accounting. These include disclosures made for treatment, payment or healthcare operations; disclosures made to you or for our facility directory; disclosures made with your authorization; disclosures for national security or intelligence purposes or to correctional institutions or law enforcement officials in some circumstances.

Right to a Paper Copy of this Notice – You have the right to receive a paper copy of this Notice of Privacy Practices, even if you have agreed to receive this Notice electronically. You may request a paper copy of this Notice at any time.

Right to File a Complaint – You have the right to complain to the Practice or to the United States Secretary of Health and Human Services (as provided by the Privacy Rule) if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. To file a complaint with the United States Secretary of Health and Human Services, you may write to: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, DC 20201. All complaints must be in writing.

To obtain more information about your privacy rights or if you have questions about your privacy rights you may contact the Practice's Privacy Officer as follows:

Name: **James DePietro, DC**

Address: **2217 West Fair Ave., Lancaster, Ohio**

Telephone No.: **740-654-3375**

We encourage your feedback and we will not retaliate against you in any way for the filing of a complaint. The Practice reserves the right to change this Notice and make the revised Notice effective for all health information that we had at the time, and any information we create or receive in the future. We will distribute any revised Notice to you prior to implementation.

I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Patient: _____ Date: _____

2217 West Fair Ave.
Lancaster, OH 43130
740-654-3375
Fax 740-654-3985
www.rehabmyspine.com

Fairfield Spine and Rehab Center, LLC

Acknowledgement of Receipt of Notice of Privacy Practices

Account #_____

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of **Fairfield Spine and Rehab Center, LLC**

I understand that the Notice describes the uses and disclosures of my protected health information by **Fairfield Spine and Rehab Center. LLC** and informs me of my rights with respect to my protected health information.

X_____ _____

Patient's Signature or that of Legal Representative *Printed Name of Patient or that of Legal Representative*

X_____ _____

Today's Date *If Legal Representative, Indicate Relationship*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ Communications barriers prohibited obtaining the acknowledgement.
- ☐ Other (please specify):_____

_____

_____ _____

Employee's Name *Today's Date*

2217 West Fair Ave., Lancaster, Ohio 43130, 740-654-3375, Fax 740-654-3985

Financial Policy Account #_____

Patient Name_____ Date_____ DOB:_____/_____/_____

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy (FP), which we require you read and sign prior to any treatment. The purpose of our FP is to keep *health care cost down*! All patients must complete and sign our entrance forms and FP before seeing the doctor.

Please read the section that pertains to your billing status.

Insurance

Our office will provide you with an EZ Insurance Verification form that you can complete on the phone or the internet to know what your chiropractic benefits are. It is your responsibility to complete and return the EZ form on your next visit. If you prefer our office to call your insurance carrier there is a $15.00 forms fee. We may accept assignment of insurance benefits; however, if an exam is completed, we request you pay $30.00 towards your exam at the conclusion of your first visit. We cannot bill your insurance company unless you give us your current insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Thus, if a referral/authorization is required it is important that you obtain one from your Primary Care Physician/or plan. If you wish to have this office file your insurance claims for you, we will require you to pay the insurance policy deductible and the patient's percentage and or co-pay as stated in your policy. If unsure of co-pay we will request you to pay $30.00 per visit until the specific co-pay amount has been provided. If your insurance company denies your claim, the balance will automatically be transferred to your responsibility.

If you are considered a "dependent" under the provisions of your insurance policy and are not personally responsible for payment of your bill, please have the policy holder(s) read and sign the financial policy.

Please be aware that some and perhaps all of the services provided may not be covered and/or not considered reasonable by your insurance policy. Regarding insurance plans where we are participating provider, all co-pays and deductibles are due at the time of treatment. In the event, that your insurance coverage changes to a plan where we are not a participating provider, refer to the paragraph regarding "Cash" patients.

I acknowledge that although I have assigned insurance benefits to this office, it is probable, that my insurance plan will not pay for all charges incurred or the coverage will be less than the amount incurred. I acknowledge that I am responsible for any charges refused or discounted by my insurance company. Further, I will pay for any collections or legal charges incurred in the collection of these uncovered charges should I fail to pay them upon request. I acknowledge that it is my responsibility to pay the balance of my bill once insurance benefits have been received.

Patient Initials X_____

Secondary Insurance

We will bill secondary insurance companies. Any amount due after your primary carrier has paid will be submitted to your secondary insurance; however, any deductibles are your responsibility.

Durable Medical Equipment: Items must be paid for at the time of service. See "Durable Medical Supply/Equipment" policy statement. We do not allow any returns on durable medical supplies and/or equipment. These will not be billed to your insurance company. You are responsible for payment. An itemized billing statement can be provided for the patient to submit to his/her insurance company for reimbursement.

Usual and Customary/Non-Covered Services

Usual & Customary Fees: our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. Durable Medical Supplies/Equipment: Refer to the "Durable Medical Policy Statement.: You will be asked to sign the DME policy statement for any supplies and/or equipment you receive (i.e. any patient receiving electrical muscle stimulation will be receiving therapy electrodes at a cost of $12 each pair). These will not be billed to your insurance company. You are responsible for payment. An itemized billing statement can be provided for the patient to submit to his/her insurance company for reimbursement.

Account #_____

Patient Name_____ DOB:_____/_____/_____

Cash Patients

FSRC offers Value Plans. This program is designed to help us improve your health and save you money.

Medicare, MediGold, Anthem Senior Advantage & other non-traditional Medicare plans

1. Medicare guidelines indicate that the only service **covered is a manual spinal manipulation.**
2. If you have a required co-payment listed on your card we will collect it at each visit.
3. **Examinations and Physical Therapies are not covered under these plans.**
4. **Medicare requires that an examination be performed by the chiropractor.** Since you are a new patient, our examination cost today is between **$80.00 and $115.00.**

Medicaid and Medicaid Managed Care Plans (MCP)

1. **Our clinic is a provider for the traditional Medical Card only.**
2. **We are not providers for any Anthem, CareSource, Molina or any other MCP. We are not authorized to bill them on your behalf. Therefore, you will be responsible for any charges incurred today.**
3. **Medicaid pays for 30 visits only within a 365 day period for children under the age of 21; 15 visits within a 365 day period for adults older than age 21. You will be responsible for any visits that exceed this allowed amount.**
4. We must have your current monthly medical card on file in order to render treatment. You will be financially responsible for any denied services that reflect a lapse in coverage.
5. No coverage is available through the Ohio Medicaid Disability Assistance Card or any other program sponsored by the Ohio Department of Human Services. You are responsible for payment of services.

Missed Appointments

If you fail to show up (no show) for your appointments, we reserve the right to charge you for your appointment. You may incur a $30.00 charge for failure to call and change or cancel your appointment. Please help us serve you better by keeping your scheduled appointments or at least call us when you cannot keep your appointment.

Missed Payments and Miscellaneous Fees

Missed payments must be paid in addition to your next scheduled payment. We accept: Cash, Personal Checks, Visa/MasterCard, American Express or Discover.

- **Interest:** 10% of the balance if not paid in full within 45 days of the current statement date.
- **Return Check Fee:** $25.00
- **Forms (per form):** $15.00 allow 3 business days
- **Collection Fee:** $25.00

I understand and accept the policy regarding insurance assignments and the Health Insurance/Cash/Medicare/Medicaid policy statement. I have received a copy of the policy statement and the fee schedule. If I discontinue care without the doctor's authorization, the balance of my account is due and payable immediately.

Further, I will pay for any collections or legal charges incurred in the collection of these uncovered charges should I fail to pay them upon request.

Patient's Signature X_____ Date X_____

Guarantor's Signature X_____ Date X_____

Fairfield Spine and Rehab Center, LLC

E-Z Patient Insurance Verification

Step #1 Patient Information Account # _____

Patient Name:_____ DOB:_____/_____/_____

If spouse/legal guardian carries the insurance plan, complete the following

Spouse's/Legal Guardian's Name:_____ DOB:_____/_____/_____

Insurance Company:_____

Step #2 Insurance Company Information (call or obtain information online)

1) Is Dr. James DePietro, DC covered with my insurance plan? **YES** **NO**
2) Effective date of policy:_____/_____/_____
3) Is this a **calendar** year or **benefit** year policy from _____ to _____? (circle one)
4) What is the deductible? $_____ Has the deductible been met? **YES** **NO**
5) Is a referral from a family physician required? **YES** **NO** If yes, please provide the name of your primary care physician._____
6) Is authorization from the insurance company required to be seen? **YES** **NO**
7) Is there a co-pay due for each visit? **YES** **NO** How much? $_____
   If no co-pay, is there a co-insurance? _____% (Example: 80/20 or 70/30)
8) How many manipulation visits to my chiropractor are covered? _____
   If no specified number of manipulation visits, are there unlimited visits? **YES** **NO**
9) How many modalities/physical therapy sessions are covered? _____
   If no specified number of modalities/physical therapy, are there unlimited visits? **YES** **NO**
10) If not managed by number of visits is my coverage determined by a set dollar amount for the calendar year/benefit year? $_____
11) I **do not have** any chiropractic benefit coverage. ☐
12) Is pre-certification required for additional testing (XRAY, MRI, CT Scan) completed by an outside facility? **YES** **NO**
    PRE-CERTIFICATION PHONE number to call is: (_____)-_____-_____
13) Are orthotics covered under my plan? **YES** **NO** If yes, is pre-certification needed? **YES** **NO**
    PRE-CERTIFICATION PHONE number to call is: (_____)-_____-_____ **Billing code L3020**

Patient Signature X_____Date X_____