Name:_____ (H) Phone:_____

Address:_____City_____ St_____ Zip_____

E-mail:_____ (C) Phone:_____

Birth Date:_____ Marital: M S W D How many Children:_____

Employer:_____ (O) Phone:_____

Occupation:_____ Spouse:_____

Emergency Contact:_____ Phone:_____

How were you referred to our office:_____

Primary Physician:_____ Last Exam:_____

Purpose of this appointment:_____

Date symptoms appeared or accident happened:_____

Have you had this condition before: Y N

If so, when and how did it occur:_____

Is this condition causing you to miss days from work: Y N Days Missed:_____

List any surgeries you have had previously:_____

_____

Serious illnesses/Complicating medical issues:_____

_____

Medications:_____

Have you had previous chiropractic care: Y N How long ago:_____

Has your condition worsened since it first started: Y N
If so, Describe:_____
How frequent is the condition: Constant_____ Daily_____ Occasional_____

Are there any other symptoms related to your pain: Y N

If so, explain:_____

Describe the pain: (check all that apply) Sharp_____ Dull_____ Tingling_____

Burning_____ Stabbing_____ Weakness_____ Other_____

Anything you can do to relieve your symptoms:_____

What makes the problem worse: Standing_____ Sitting_____ Laying_____

Lifting_____ Bending_____Twisting _____ Other _____

Have you ever broken any Bones: Y N If so, list_____

To your knowledge, have you had any diseases, illnesses or injuries not indicated on this form with in the presently or in the past: Y N, If so, explain:_____

Women Only, Are you pregnant: Y N Uncertain

On a scale of 1 to 10 with 10 being the most extreme, how would you rate your pain:____

Please indicate any and all insurance coverage that may be applicable in this case:

Medical Insurance_____ Insurance Company:_____

Do you have a secondary coverage or any health savings, flex spending accounts: Y

Name of Secondary Insurance if applicable_____

Are you currently seeking a Workers Compensation Claim thru your employer: Y N

Is this the result of an auto accident: Y N

If so, name of responsible insurance company:_____

Claim #:_____ Adjusters Name_____

Patient Signature:_____Date:_____

Financial Policy

Our recommendations are based upon a desire to see you get well and stay well. Chiropractic care is covered by many insurance plans. Most of our patients that have health or accident policies will be covered under one of the plans discussed in this policy. Regardless of your coverage, we'll suggest the chiropractic care we think you need. We ask that you read and understand our policy as it applies to your particular situation.

Patients Without Insurance

We request that all payments for services paid at the time of service. If financial assistance is needed, please discuss any need for payment arrangements prior to receiving care. We are committed to working with you regarding your health and do not want financial situations preventing you from receiving the care you need. Our office accepts cash, debit, credit and personal checks. Any returned checks will result in a returned check fee of $25 and we will be unable to accept personal checks moving forward.

Group or Individual Insurance Coverage

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. Although we do our best to verify insurance coverages and benefits, the amount of coverage and benefits varies from one policy to another and depending on your deductible, copay and co-insurance requirements. When possible, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and then file them with your insurance company. It is understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductible, co-pays or co-insurances.

Flex Plans/Health Savings Accounts

Please inform us if you have a health savings account or a flex spending account. We will be happy to provide you with a statement of your account for reimbursement if necessary.

Managed Care Plans

We are preferred providers for many HMO'S that may require authorization or referral from your primary care physician and/or the insurance company prior to receiving care. When possible, we can assist you in obtaining a referral prior to services. In some cases the required time and/or paperwork may delay your care, if treatment is

received prior to obtaining a referral you will ultimately be responsible for all incurred charges.

Personal Injury/ Automobile Accidents

Please present all applicable information such as Auto verification card, claim number, adjuster name and attorney info if applicable. There are three options for payment available for a personal injury patient.

1. Pay cash for your care and we will submit claim info and bill when needed for reimbursement.
2. We will bill from the MedPay portion of your auto coverage if applicable.
3. We will file a medical letter of protection or Doctors Lien and await payment at the time of settlement. You also agree to allow payment for your care to be made directly to our office from any responsible party on your behalf.

Although you are ultimately responsible for your bill, we will await settlement of your claim for up to 6 months from the conclusion of your care. After six months, we reserve the right to attempt to collect our charges from you regardless of any ongoing legal matters or attorney involvement.

Medicare

We do accept assignment from Medicare. Payment is typically sent to our office for reimbursement of **covered** services - which is only the manipulation of the spine. **Medicare does not cover exams and x-rays. You are personally responsible for these charges.**

Medicare pays 80% of the allowable fee once your annual deductible has been met. In the absence of any secondary insurance coverage, you are required to pay the deductible and the remaining 20% of charges. Any non-covered services will be your responsibility, our office will notify you of any services prescribed which are not covered by medicare prior to treatment. Our office completes and files the forms for Medicare at no charge.

Overdue/Past Due Policy

Accounts 90 days past due may be referred to collections for payment. This is a last resort action on our behalf. Please let us know if a payment arrangement needs to be made in order to reconcile your account. We do not wish to send anyone to collections.

I have read and understand the financial policy of Landreth Chiropractic.

_____ _____

Patient Signature **Date**

Informed Consent Document

Patient Name: _____

To the Patient: Please read the entire document prior to signing. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment:

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use hands or a manipulative 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 part of the analysis, examination, and treatment, you are consenting to the following procedures:

Spinal manipulative therapy, palpation, vital signs, range of motion testing, orthopedic testing, basic neurological testing, muscle strength testing, postural analysis testing, ultrasound, hot/cold therapy, EMS, radiographic testing, acupuncture, spinal decompression and massage therapy.

If you have any questions or concerns regarding any of these procedures please bring it to the attention of the physician.

The material risk inherent in the chiropractic adjustment:

As with any healthcare procedure, there are certain complications, which 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. The Doctor 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 the Doctor's attention it is your responsibility to inform the Doctor.

The probability of those risks occurring:

Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during examination and radiographs. Stroke and/or vertebral artery dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident and is rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of a vertebral artery stroke.

The availability and nature of other treatment options:

Other treatment options for your condition may include:

- Self-administered, over-the-countered analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you choose 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, which 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 treatment is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed any concerns with the Doctor and 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

Patient Health Information Consent Form

We want you to know your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign his consent form stating that you understand and agree with how your records will be used.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, health care operations and coordination of care. As an example, the patient agrees to allow this to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit release of all PHI to the minimum needed for what the insurance companies require for payment.

1) The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

2) A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.

3) The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given prior to the written request has been presented.

4) For your security and right to privacy, all staff have been trained in the area of patient record privacy and a privacy office has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those that do not need them.

5) Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

6) If the patient refuses to sign this consent for the purpose of treatment, payment and health re operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient **Date**

Appointment Cancellation Policy

Making your scheduled appointments is critical to the progress and ultimate outcome of your treatment. We encourage you to make all of your scheduled appointment times but we also understand things happen from time to time. We ask that you provide at least 24 hrs notice when rescheduling an appointment when possible. Cancellations within 2 hrs of your scheduled appointment or repeated cancellations may result in a $25 charge and will result in our inability to reserve an appointment time for future treatment.

I have read and understand the Appointment Cancellation Policy of Landreth Chiropractic.

_____

Patient Signature