Patient Information

Date: _____

How did you hear about us? ☐ Patient ☐ Physician ☐ Attorney ☐ Google ☐ Other_____

Last Name: _____ **First** Name: _____ Middle: _____

Address: _____ Apt/Lot# _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Birth Date: _____ Social Security# **XXX - XX -** _____

Email Address: _____

Employer: _____ Employer # _____

>>> Spouse's Name & #: _____

>>> -or- Emergency Contact Name & #: _____

Emergency Contact's relationship: Significant Other Parent Child Friend Other _____

Main Complaint: _____

_____

Date of Accident: _____ -or- Date of Symptom Onset: _____

Description of Accident: _____

_____

_____

_____

Have you consulted anyone else for this condition?

☐ YES ☐ NO

Physicians Name: _____

Location: _____

Allergies? _____

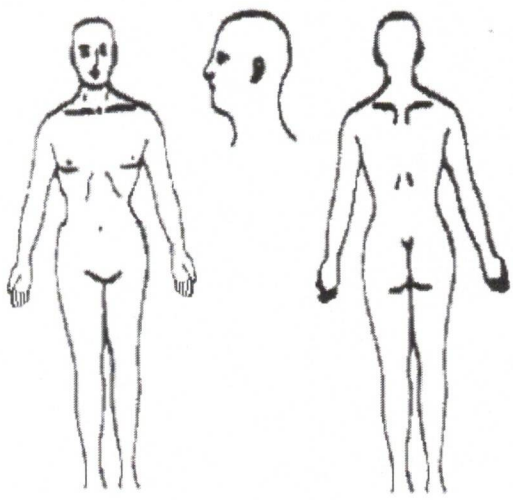
Please Mark Pain Scale with an X

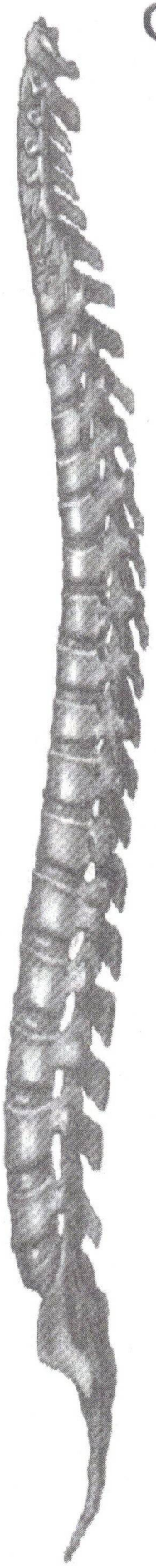
NO Pain Severe Pain

0 | | | 5 | | | 10

Method of Payment: ☐Cash-Check-Card ☐ Insurance

Mark Areas: **Pain = X** **Numbness = O**





Gulfview Chiropractic & Wellness Center

Dr. Charles Halley

Patient Name_____ Date of Birth _____

General Consent to Treat

I voluntarily consent to medical care of a routine/emergency nature form the authorized professional staff of Gulfview Chiropractic for myself or the above-mentioned minor for whom I am the parent/guardian. I authorize the release of any and all medical records and information obtained through my medical evaluation to those individuals that my doctor feels appropriate for my continued medical care. I understand that I have the right to a full disclosure of the nature of any medical treatment received or proposed to be rendered and the risks, if any, involved and alternative means available. It is understood that I may withdraw this consent at any time by contacting any member of the professional staff in writing.

Financial Agreement

I authorize payment to Gulfview Chiropractic of any medical benefits, which would otherwise be payable to me and which were established by my insurance company. The amount paid to Gulfview Chiropractic shall not exceed the practice's regular charges for the services. I also authorize the release of my medical records to my insurance company/companies or other third party payers or my employer as required for the collection of payments. I understand that I am responsible for the payment of charges that are not paid by my insurance company.

Medicare Agreement

The information provided by me in applying for payment of Social Security benefits is true and correct. I also authorize the physician to initiate a complaint to the insurance commissioner for any reason on my behalf. I request that the payment of benefits be made for me. The benefits due to me for services provided by my physician shall be paid directly to the Gulfview Chiropractic. In the event the physician does not receive such payment I authorize such physician to submit a claim to Medicare on my behalf. If my current policy prohibits direct payment to the Gulfview Chiropractic, I hereby direct the checks made out to me and mailed to Gulfview Chiropractic & Wellness Center, 8323 U.S. Hwy 19 Port Richey FL. 34668.

Payment Agreement

Our office requests that you read your insurance policy and by fully aware of any limitations of the benefits provided. You should be aware that this insurance agreement is between you and the insurance company. We will gladly help, you but it is your responsibility to know the limitations or your policy. Any change incurred beyond the reimbursement of your policy will be your financial responsibility.

HIPAA

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

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

I have read the above and understand my financial obligation.

Patient Signature_____Date_____

Spouse/Guarantor Signature/Relationship_____

Witness _____ Date_____

Gulfview Chiropractic and Wellness Clinic

In accordance to HIPAA practices, I authorize my medical information to be released to the following person(s):

___ NO other person

☐ Spouse_____

☐ Doctor_____

☐ Doctor_____

☐ Child_____

☐ Child_____

☐ Child_____

☐ Child_____

☐ Other_____

☐ Other_____

☐ Other_____

_____ _____

Signature Print Name

_____

Date

A. Notifier: **Gulfview Chiropractic & Wellness Clinic**

B. Patient Name: _____ **C. Identification Number:** _____

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** Exam, Therapy and Modalities below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** Exam, Therapy and Modalities below.

D. Exam,Therapy and Modalities	E. Reason Medicare May Not Pay:	F. Estimated Cost
Medically necessary non-covered services: Exam, Therapy Services (E-Stim w/Ice or Heat, Traction, Massage), Modalities (therapeutic tools used to help patients recover)	Medicare does not pay for Chiropractic Physicians' Exams, Chiropractic Physical Therapies, Chiropractic Physical Modalities, Chiropractic Orthopedic Supports, or Chiropractic X-Rays.	Exam $30 E-Stim $10 Electrodes $10 Traction $10 X-Rays $30 Modalaties $30-$75

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** Exam, Therapy and Modalities listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** Exam, Therapy and Modalities listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** Exam, Therapy and Modalities listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.** Exam, Therapy and Modalities listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

Gulfview Chiropractic & Wellness Center

ASSIGNMENT OF BENEFITS, AUTHORIZATION TO SETTLE CLAIM AND DIRECTION TO PAY MEDICAL PROVIDER DIRECTLY

By my signature below, for good and valuable consideration (including but not limited to the extension of credit to me), I hereby assign, transfer and convey to **Dr. Charles Halley / Gulfview Chiropractic** (hereinafter "the Provider") all of my rights, title and interest in and to medical expense reimbursement in whatever form, including but not limited to any automobile liability medical expense payments or other health benefits indemnification and/or agreement otherwise payable to me. This payment shall not exceed my indebtedness to the above named assignee and I acknowledge that I will timely pay any indebtedness owed by me to the assignee that is not otherwise satisfied by the above-mentioned assigned proceeds. I also acknowledge that any medical expenses not covered under my insurance policy will be my responsibility.

I further authorize the Provider to negotiate, collect and settle any claim with any insurance carrier or other third party payor with regard to these services, which authorization shall include authority to:
(1) request and receive from any insurer or any other party any and all documentation and records that I am empowered to request regarding this claim, including, without limitation, a statement of coverage, policy declarations page and insurance policy pursuant to Section 627.4137. In addition, the provider has the authority to request and receive any Independent Medical Examination Reports, notices sent to me regarding appointments for Independent Medical Examinations and Examinations Under Oath (including proof of mail), Records Review Reports, coverage denial letters, Explanations of Benefits, and Benefit Payment Sheets or Logs (P.I.P. Payout Sheets), without regard as to whether such documentation has already been provided to me and,
(2) to endorse in my name any check issued for payment where benefits were assigned. By way of this assignment and notice, I further instruct you, the insurer, to furnish to Provider copies of all future notices affecting Provider's interest in this claim, including, without limitation, any notices of requested medical examinations or statements and,
(3) to institute any necessary litigation and/or complaints against my insurance policy, naming me as plaintiff in such lawsuits and actions if necessary (or me as guardian if the patient is a minor).

The Provider hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit *shall not* be deemed a waiver, *accord, satisfaction*, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full.

I further direct my insurer to direct all payments for services rendered by the Provider directly to Provider at the billing address contained on Provider's medical bills.

THIS IS A DIRECT AND IRREVOCABLE ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY POLICY OF INSURANCE.

A photocopy of this form shall be considered as effective and valid as the original.

I have read the foregoing and understand and agree to each of the above provisions:

_____ _____

Patient's signature Date

8323 US 19, Port Richey FL 34668 Phone: 727-847-4611 Fax: 727-842-3524

Patient Request for Records

I hereby authorize the release copies of my records and x-rays and request that they be sent to:

Dr. Charles Halley

Gulfview Chiropractic & Wellness

8323 US Highway 19

Port Richey, FL 34668

gulfview.chiropractic@gmail.com

Fax (727) 842-3524

Print Name of Patient: _____

Signature of Patient: _____

SSN: XXX-XX-_____ **Date of Birth (DOB):** ____-____-_____

FOR OFFICE USE ONLY

Date: _____-_____-_____

To: _____

(Doctor/Hospital)

Address: _____

City: _____ **St:** _____ **Zip:** _____

Phone: (____)_____-_____ **Fax:** (____)_____-_____

GulfView Chiropractic

CANCELLATION POLICY CONSENT

EFFECTIVE 2019

We understand occasionally missed appointments happen, for various reasons. When you miss an appointment without canceling in a timely manner, other patients who could have been seen in your place may be unnecessarily delayed. Thus we have a 2 hour minimum cancellation notice policy. "No-Show" or "Late Cancellation" is defined in our office as missing an appointment without canceling at least **2 hours prior** to the scheduled appointments.

There will be a charge for every no-show and late cancellation, less than 2 hours prior to the agreed-upon appointment time scheduled. **A simple phone call as common courtesy will allow you to avoid these fees.** There will be a one-time forgiveness, because we understand "Life Happens". This fee is non-negotiable and will be paid by your attorney before any settlement funds are distributed.

INSURANCE WILL NOT PAY FOR THESE FEES

A $50 CHARGE WILL BE PLACED ON YOUR ACCOUNT FOR EACH MISSED APPOINTMENT THAT HASN'T BEEN CANCELLED 2 HOURS PRIOR TO THE SCHEDULED TIME.

_____ _____

Patient Signature Date

Missed Appointment Date(s)	Fee(s)
_____	1st FREE
_____	_____
_____	_____
_____	_____

8323 U.S. Hwy 19 Port Richey FL 34668 Phone: 727-847-4611 Fax: 727-842-3524