Taylor Chiropractic

Dr. Brett Taylor
911 Dix St., Suite D • Otsego, MI 49078
269-694-5871

Patient Information

Name: _____

Height: _____ feet _____ inches **Weight:** _____ lbs. **Right or Left-Handed**

Birthdate: _____ **Email:** _____

Best Number to Reach You: _____

Home Address:_____**Zip Code:** _____

Employer: _____

Emergency Contact:

Name: _____ **Relation:** _____

Phone: _____

How did you hear about our office? _____

Insurance Information

Name of Medical Insurance Company: _____

Member ID Number: _____

HSA or FSA Card (circle one) – YES or NO

Most Supplements are Covered by FSA or HSA Cards Including your visits.

If the Policy Holder is different than the patient, the following information is needed for billing:

Policy Holder Name: _____

Date of Birth: _____ **Relation to patient:** _____

Policy Holder Address: _____

Medication History

Do you have any medication allergies? **Yes** **No** If yes, what? _____

List Current Medications if any: _____

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Medical History

Please list any current or past medical conditions, or surgeries (diabetes, cancer, etc.): **If None please put NONE:**

_____

Primary Physician: (BCBS patients must have a Primary Physician on file)

_____

What is the reason for your visit today: _____?

What is the onset date of your injury/pain: _____?

Family Medical History

Please list any current or past medical history of family members (diabetes, cancer, etc.)

Maternal:_____
Paternal: _____
Siblings: _____

Social History

Do you use: **Coffee** **Alcohol** **Tobacco**

Smoking Status

- ☐ Current daily smoker
- ☐ Current some day smoker
- ☐ Former Smoker
- ☐ Never Smoker

Marital Status: S M D W

Do you have children: yes no

If so, how many:_____

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For office use only:

Date: _____

Patient: _____

Assignment of Insurance Benefits

I, _____, understand that services rendered to me by Taylor Chiropractic are my financial responsibility and that the provider will bill my insurance company, _____ as a courtesy. I authorize my insurance company to pay my benefits directly to Taylor Chiropractic and I understand that I will be fully responsible for any outstanding balance on my account. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in the current manner, any balance of said professional service charges over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by _____ (insurance company).

I authorize the provider to release any information necessary to adjudicate the claim and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

I also understand that should insurance company send payment to me; I will forward the payment to Taylor Chiropractic within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event the patient receives any check, draft, or other payment to provider. Any violations of this agreement will, at provider's election, terminate patient charge privileges with provider and bring any balance owed by patient to provider immediately due and payable.

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To avoid this additional cost and inconvenience, should the insurance company forward payment to me, I authorize Taylor Chiropractic to facilitate payment utilizing the credit card on file to resolve balance. A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize the provider to initiate a complaint of file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

Date: _____

Signature: _____

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Financial Agreement

We, the staff at Taylor Chiropractic, thank you for choosing us as your healthcare provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship and our goal is to not only inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies or responsibilities please feel free to contact us at 269-694-5871. We believe this level of communication and cooperation will allow us to continue to provide quality service to all our valued patients.

Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance, or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service unless a payment arrangement has been approved in advance by our staff.

We make payment as convenient as possible by accepting (cash, money order, MasterCard, Visa, Care Credit, and in-state checks). A $45.00 service fee will be charged for all returned checks. Additionally, you may authorize us to keep your credit card on file for your convenience, knowing that we adhere to the highest level of information security.

If no payment has been made after 90 days, your account will be sent to collections. If your bill is sent to collections, it must be paid in full before returning for services; services thereafter will need to be paid in full at the time of service.

Insurance
Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims. It is your responsibility to provide all necessary insurance eligibility, identification, authorization, and referral information and to notify our office of any information changes when they occur.

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Even a pre-authorization of services does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information.
It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect co-payments, co-insurance, and deductibles, as outlined by your insurance carrier.

Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of network fees. If we are not contracted with your carrier, we will not negotiate reduced fees with your carrier.

Miscellaneous Forms, Additional Information and Authorizations
We will provide all necessary information to have your benefits released. However, if it becomes necessary to submit redundant or unnecessary information for the completion of claim forms for school, sports, or extracurricular activities there will be an administrative fee, not to exceed $45.00, for the additional information.

Missed Chiropractor Appointments
We require notice of cancellations 24 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointments without notifying us in advance: a missed appointment fee will incur. These fees are typically $20.00 but not to exceed half of the cost of your scheduled appointment.
Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients.

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Medical Records Fees

Patients are entitled under federal law to have access to their protected health information, and we follow all rules, guidelines, and exceptions to ensure compliance to patient rights. However, providers also have the right to compensation for records and our fees are a reasonable cost-based fee for copies including the copying, supplies, labor, and postage of the files and or summaries.

We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business.

Timeliness of Appointments

We try to see everyone in a timely manner but if we are taking too long, please let our receptionist know so we can best serve your needs and reschedule you if necessary.

I have read and understand the above financial policy. I agree to assign insurance benefits to whenever applicable. I also agree, in addition to the amount owed, I will also be responsible for the fee charged by the collection agency for the costs of collections if such action becomes necessary.

Date: _____

Print Name: _____

Signature of Insured or Authorized Representative: _____

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Chiropractic Therapy Services
Patient Consent, Pricing & Medicare ABN Notice

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

Therapy Services Offered & Pricing (Per Session)

- Electrical Therapy (E-Stim) — $20.00
- Spinal Decompression Therapy — $20.00
- Ultrasound Therapy — $20.00
- Trigger Point Therapy — $20.00

Important Medicare ABN Notice

Medicare does not cover certain chiropractic therapies, including electrical stimulation, ultrasound therapy, decompression therapy, and trigger point therapy, as they are considered maintenance or supportive care. Medicare is expected to deny payment for these services.

By signing below, you acknowledge that you understand Medicare is likely to deny payment, you agree to be personally responsible for $20.00 per therapy per visit, and you may refuse these services or request a claim submission to Medicare.

Patient Signature: _____ **Date:** _____

Provider / Staff Signature: _____ **Date:** _____

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HIPAA Consent Form

I give Taylor Chiropractic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies and for health care operations like quality reviews.

I have been informed that I may review the clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent. I understand Taylor Chiropractic has the right to change their privacy practices and that I may obtain any revised notices at the clinic. I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that Taylor Chiropractic is not required to agree to the request. If Taylor Chiropractic agrees to my requested restrictions, they must follow the restriction(s). I also understand that I may revoke this consent at any time, by making a request in writing, except for the information already used or disclosed.

_____ _____

Patient or Guardian Date

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Informed Consent

Dear Patient, Every type of health care is associated with some risk of potential problems. That includes chiropractic health care. We wish you to be informed about the possibility of any potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Consent to Treatment - The following points have been explained to me to my satisfaction and I have had the opportunity to discuss them with the doctor and/or other clinic personnel.

1. I understand that the chiropractor will use his/her hand or a mechanical device upon my body to adjust a joint, and there may be an audible “pop” or “click” as result of joint movement.

2. The practice of health care is not an exact science, but relies upon information relayed by the Patient, information gathered during the examinations (and the doctor’s interpretation thereof), as well as the doctor's judgment and expertise. Chiropractic care is no different.

3. It is not reasonable to expect my doctor to anticipate or explain all possible risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise professional judgement during the course of any procedures that he/she feels at the time to be in my best interest.

4. Though infrequent, as with any health procedure, there are certain complications that may arise during chiropractic health care. These complications include soreness, sprain/strains, dislocation, fractures, disc injuries, cerebral-vascular accidents, physiotherapy burns, or soft tissue injuries. These complications are extremely rare occurrences.

5. Chiropractic is a system of health care delivery; therefore, as with any other health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will give you our best care.

6. I understand that there are other forms of treatment, including drugs and surgery, which could be treatment options for my condition, but at this time, I choose chiropractic care.

By signing this Confidential Patient Information intake form I acknowledge that I have read the above consent, or it has been read to me. I have had the opportunity to ask questions and receive answers; I am comfortable with the information provided and consent to chiropractic treatment and management on that basis. In signing this document, I in no way compromise my protection against negligence.

_____ _____

Patient or Guardian Date