Financial Policy- Private Insurance

1. For those patient who are covered by private insurance, it shall be your responsibility to confirm the specifics of your insurance coverage as this is not a responsibility of our office.
2. Our clinic will be happy to bill directly to your insurance carrier provided that you are eligible for chiropractic care and the required medical services, and that we have your complete insurance information such as insurance company's name, address, telephone number, policy/claim number, etc. You will have to pay on the first visit the yearly deductible and the appropriate insurance copayment, if applicable, as services is rendered.
3. If your insurance company has not paid within 45 days after the billing date, our office reserves the right to bill the patient for the amount due. It shall be the patient's responsibility to deal with their respective insurance company when there is a question of the incorrect fee payments or non-payment for services rendered.
4. Accounts that are thirty (30) days past due are subject to a 1% finance charge per month, interests charge are payable on a monthly basis regardless of the type of the insurance coverage.

Agreement of Insurance Benefits & Authorization for Release

1. I agree and acknowledge that my signature on this document authorizes my physician to submit claims for payment of services rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependants, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I, _____(Name of the Insured)/_____(Policy number) hereby assign to and authorize _____(Name of Insurance Company) to pay by check make out and mail directly to: Active Spines, Inc. all benefits if any, otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. This payment shall not exceed my indebtedness to above mentioned assignee and I have agree to pay in a current manner, any balance of professional service charges over and above this insurance payment. <u>This assignment is effective for any/all treatments received by me during the applicable year in which treatment is received.</u> I also authorized Active Spines, Inc. to release any information required relating to all claims for benefits submitted on behalf of myself and/or dependant.
2. I clearly understand the above policy and agree that I am financially responsible for payment of services rendered to me and if my account is sent to a collection agency. I am responsible for any attorney fees incurred.
3. Our practice firmly believes in establishing excellent doctor/patient relationships, which are rooted in good communication and understanding. Missed appointments hinder that relationship. As a courtesy to Active Spines Chiropractic's patients and staff, please give 24-hour notice for all cancelled appointments if it is within your control. **No show or no call will result in a $45.00 charge.** We appreciate your consideration in this matter.

Patient: _____ Date: _____

Parent/Guardian: _____ Date: _____

Witness:_____ Date:_____

PRIVACY POLICIES

It is our desire to communicate to you that we take the Federal HIPAA (Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your personal health information seriously. We want you to know about our policies and procedures that we have developed in order to make sure your health information will not be shared with anyone who does not require it. We will use and communicate your health information only for the purposes of providing your treatment, obtaining payment, and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

HOW YOUR HEALTH INFORMATION MAY BE USED

To Provide Treatment: We will use your health information within our office for clinical office procedures to optimize scheduling and coordination of care between the doctors of this clinic and any other clinician you may be seeing at the same time.

To Obtain Payment: We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forums filed for you in the mail or sent electronically. We will be sure only to work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations: Your health care information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. Health information may be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews.

For Patient Reminders: Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up with your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventative and curative care. They may be postcards, folding postcards, letters, telephone or text reminders, or electronic reminders such as e-mail (unless you inform us you do not wish to receive these reminders).

Abuse or Neglect: We will notify government authorities if we believe a patient is the victim of abuse, neglect, or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law, or with the patient's agreement.

Public Health and National Security: We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security.

For Law Enforcement: As permitted by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including under certain circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends, and Caregivers: We may share your health information with those you tell us will be hel[ing you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency where you are unable to tell us what you want, we will use our very best judgement when sharing your health information only when it will be important to those participating in your care.

To Coroners, Funeral Directors, and Medical Examiners: We may be required by law to provide information to coroners, funeral directors, and medical examiners for the purposes of determining a cause of death and preparing for a funeral.

Health Care Research: Advancing health care knowledge often involves learning from the careful study of the medical history of prior patients. Formal review and study of health history as a part of a research study will happen only under the ethical guidance, requirements, and approval of an institutional review board.

Authorization to Use or Disclose Health Information: Other than is stated above or where Federal, State, or local law requires use, we will *not* disclose your health information other than with your written authorization. You may revoke said authorization in writing at any time.

YOUR RIGHTS AS A PATIENT

Restrictions: You have the right to require restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications: You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present, or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information: You have the right to read, review, and copy your health information, including your complete chart and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information: You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. Please provide us with your request in writing and describe your reason for the change. Your request may be denied if the health information records in question were not created by our office, are not part of our records, or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information: You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payments, or health operations. Please let us know in writing the time period for which you are interested. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of This Notice: You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. We are required by law to maintain the privacy of your health information and to provide you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice, but we do reserve the right to change the terms of our Notice. If we change our privacy practice, we will be sure all of our patients receive a copy of the revised Notice. You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised.

Patient Name:_____ Signature:_____ Date:_____

Active Spines CHIROPRACTIC

Patient and Insurance Information

Name Email Date

Address Apt #

City State ZIP

Cell Phone Home Phone Work Phone

Drivers License # Birth Date Soc Sec #

Marital Status M S D Sep Spouse Name # of Children

Referred By: Age Range of Children

Employer Occupation

Address

Town State ZIP

Health Insurance Info

Carrier Ins Co phone

Address

Policy # Group #

Patient Relationship to the insured Self Spouse Child Other

If you are covered under another persons insurance…. Please complete

Name of Insured

Address of insured

Phone of insured Sex Birth date

Insured's Employer

Address

Employer Phone Plan Name

Auto Accident Insurance

Policy Number

Carrier

Address

City State ZIP Phone

Person To Contact… Claim #

Date of Accident Patient Relationship to the insured Self Spouse Child Other

Initial:_____

Active Spines CHIROPRACTIC

Patient initial exam intake form

Patient Name:_____ Today's date: _____

Symptoms began on:_____

1. Briefly describe your symptoms:_____

   _____

2. How did your symptoms starts?_____

   _____

3. Average pain intensity:

   Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

   Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

4. How often do you experience your symptoms?

   1) Constantly (76% to 100% of the time) 2) Frequently (51% t o75%) 3) Occasionally (26% to 50%)

   4) Intermittently (0% to 25%)

5. How much have your symptoms interfered with your usual daily activities?

   1) Not at all 2) A little bit 3) Moderately 4) Quite a bit 5) Extremely

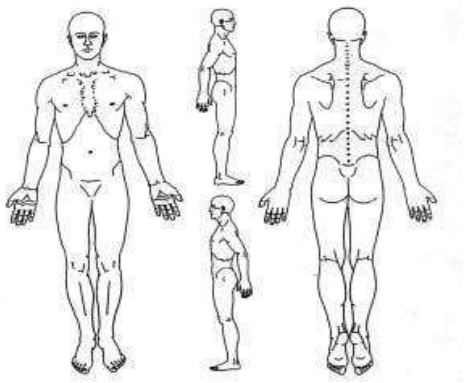
6. How is your condition changing, since care began at this facility? Or N/A- initial visit

   worse 0% 5% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% better

7. In general, would you say your overall health right now is…

   1) Excellent 2) Very good 3) Good 4) Fair 5) Poor

8. Please Circle the Area of Pain:



9. If you have been off from work, have you returned to work yet? YES NO

   If YES, date returned to work: _____

Past Health History:

A. Previous illnesses you've had in your life: _____

B. Previous injury or trauma/Have you ever broken any bones? _____

C. Allergies:_____

D. Medications: _____

E. Surgeries:_____

F. Females/ Pregnancies and outcomes:_____

What was the date of the beginning of your last menstrual period? _____

Family Health History:

Associated health problems of relatives: _____

Social and Occupational History: Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):_____

Review of Systems – (Check box if you have had trouble with any of the following)

Cardiovascular			No	**Respiratory**			No	**Allergic/Immunologic**			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								**Ear, Nose and Throat**			No
Jaw Pain				**Eyes**			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				**Psychiatric**			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				**Gastrointestinal**			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				PMS				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				**Hematologic**			No				
Pinched Nerves					Past	Present		**Musculoskeletal**			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain				Varicose Vein				Joints Replaced			
Low Energy Level								Neck Pain			
Difficulty Sleeping								Low Back Pain			
								Upper Back Pain			

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature: _____ Date:

Witness Name: _____ Signature: _____ Date: