CHAPEL, MCMURTRIE & BARTLETT CHIROPRACTIC ORTHOPEDICS

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Name _____ Date of Birth _____ Sex: F M

Address _____ City _____ State _____ Zip _____

Phone _____ [Home – Mobile – Work] Other Phone _____ [Home – Mobile – Work]

Social Security # _____-_____-_____ E-Mail Address _____

Race: African American
Alaska Native
American Indian
Asian
Native Hawaiian
White
Other Pacific Islander

Ethnicity: Non-Hispanic or Non-Latino
Hispanic
Latino

Height _____ Weight _____

Do you smoke? *Yes or No*
---- *if yes, how much?* _____

Are you a former smoker?
Yes or No

How were you referred to our office? _____

Employer _____ Occupation _____

Describe Daily Duties _____

Hobbies + Recreational Sports _____

Marital Status *Single Married Separated Divorced Widowed* *(please circle one)*

Spouses Name _____ Spouses Employer _____

Children [Names + Ages] _____

Current Medications _____

Primary Physician _____ Females: Are you Pregnant? *Yes or No*

Is this condition related to an automobile injury or worker's compensation claim? *Yes or No*

What is your major complaint? _____

How did the injury occur? _____

Date of Injury _____ Have you seen any other therapists or doctors for this condition? *Yes or No*

If yes, please list provider names _____

What activities make the problem worse? _____

What activities make the problem better? _____

Is this condition getting better or worse? _____

Is the pain constant or does it come and go? _____

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Please indicate [1] if previously had OR [2] if presently have for conditions listed below:

MUSCULO-SKELETAL
___ Low Back Pain
___ Pain Between Shoulders
___ Neck Problems
___ Arm Problems
___ Leg Problems
___ Painful Joints
___ Stiff Joints
___ Sore Muscles
___ Weak Muscles
___ Broken Bones

NERVOUS SYSTEM
___ Numbness
___ Loss of Feeling
___ Paralysis
___ Dizziness
___ Fainting
___ Headaches
___ Muscle Jerking
___ Convulsions
___ Forgetfulness
___ Confusion
___ Depression
___ Anxiety

CARDIOVASCULAR & RESPIRATORY SYSTEM
___ Chest Pain
___ Difficult Breathing
___ Persistent Cough
___ Coughing Blood
___ Rapid Heartbeat
___ Blood Pressure Problems
___ Heart Problems
___ Lung Problems

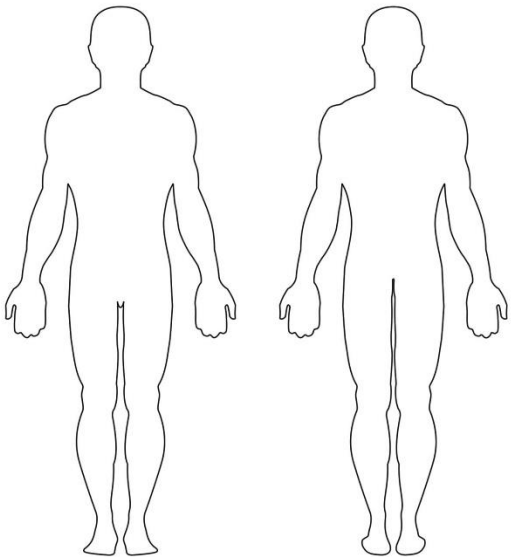
FEMALE
___ Vaginal Bleeding
___ Vaginal Discharge
___ Breast Pain
___ Breast Augmentation
___ Lumps in Breast

URINARY
___ Bladder Trouble
___ Excessive Urine
___ Painful Urination
___ Discolored Urine

OTHER: _____
_____
_____

GASTRO-INTESTINAL
___ Poor Appetite
___ Excessive Hunger
___ Difficulty Swallowing
___ Nausea
___ Vomiting Food
___ Vomiting Blood
___ Abdominal Pain
___ Diarrhea
___ Constipation
___ Black Stool
___ Bloody Stool
___ Hemorrhoids
___ Liver Trouble
___ Gallbladder Problems
___ Weight Trouble

Using the symbols given, mark the areas on your body where you feel the described sensations – please include all affected areas.



NUMBNESS
- - - - - - - - -

PINS + NEEDLES
00000000000

BURNING
xxxxxxxxxx

ACHING
****

STABBING
//////////////////

Please list all hospitalization & surgeries: _____
_____
_____

Patient Signature _____ Date _____
(if patient is minor, guardian or parent signature)

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Chiropractic treatment, including spinal adjustments, have been the subject of government reports and multi-disciplinary studies conducted over many years and have been demonstrated to be effective treatment for many neck & back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well-being. The risk of injuries or complications from Chiropractic treatment is substantially lower than associated with many medical or other treatments, medications and procedures given for the same symptoms.

Doctors of Chiropractic who use manually therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

1. While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques.

2. There are reported cases of cerebral vascular accident associated with many common neck movements. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently and estimated at one per one million. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustments is extremely remote.

3. There are rare reported cases of aggravation of existing disc conditions following cervical and lumbar spinal adjustments although no scientific study has ever demonstrated such injuries are caused by spinal adjustments or Chiropractic treatment.

I acknowledge that if I have any questions regarding the nature and purpose of my Chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the content of the consent, I will ask my Chiropractor in advance.

I consent to the Chiropractic treatment offered or recommended to me by my Chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future Chiropractic care.

Today's Date: _____

_____ _____

Patient Signature
(if patient is minor, guardian or parent signature)

Printed Name of Patient

_____ _____

Signature of Witness

Printed Name of Witness

PERSONAL MEDICAL INFORMATION CONSENT – HIPAA

The Health Insurance Portability Accountability Act of 1996 [HIPAA] requires that we receive your permission before we use the personal information in your medical records for any reason. This consent form gives us permission to use your Protected Health Information [PHI] to carry out treatment, and/or for healthcare operations of our practice.

HIPAA also requires us to have a written notice of our privacy policy describing how medical information about you may be used and disclosed. If you so desire, this written notice is available at the front desk for you to read. HIPAA gives the patient a right to add restrictions to the release of PHI. We as an office do not have to agree to these restrictions, but if we do, they are legally binding.

You have the right to revoke, in writing, this consent at any time, although any services performed prior to the revocation of this consent are covered by this consent. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

As permitted by law – Chapel, McMurtrie & Bartlett Chiropractic Orthopedics reserves the right to amend or modify our privacy policies and practices. A change in our office policies and practices may be required by changes in federal and state laws and regulations. Upon receipt, we will provide you with the most recent notice at your next office visit. The revised policies and practices will be applied to all protected health information we maintain.

_____ _____

Patient Signature — Date

(if patient is minor, guardian or parent signature)

I consent Chapel, McMurtrie & Bartlett Chiropractic Orthopedics to share my personal health information, appointment information, billing information, to the below named individuals to access information pertaining to my account. This may include, but is not limited to past appointments times, billing information, and insurance information. It is the patient's responsibility to contact us if any name listed below would need to be removed.

❒ *I do NOT wish to list anyone on my HIPAA consent form.*

_____ _____

Name — Relationship

_____ _____

Name — Relationship

_____ _____

Witness / Staff Signature — Date

PAYMENT POLICIES

We, the staff of Chapel, McMurtrie & Bartlett Chiropractic Orthopedics thank you for choosing us at your medical 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. We believe this level of communication and cooperation will allow us to continue to provide quality service to all our valued patients.

Patient portions [*Co-Pays, Co-Insurance, Deductibles*] ***are collected at each visit***. We accept Personal Check, Visa, Mastercard, Discover, American Express, Apple Pay, Android Pay, HSA/HRA/FSA Cards. A $35 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.

HEALTH INSURANCE

We do accept most insurance plans, and most insurance plans DO cover Chiropractic Care. 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 allowed benefit under your policy. It is your responsibility to give the correct information about your current insurance company and is YOUR responsibility to follow the rules outlined by your insurance company. [ex: Authorizations and Referrals]

We will verify your chiropractic insurance benefit coverage. We will collect any co-payment and/or deductible amounts quoted by your insurance provider at the time services are rendered. If there are any discrepancies when the claims are processed, you may be responsible for any additional balances. We advise you to contact your insurance company to verify your benefits. If you are told different benefits, please advise our office.

We will submit claims for services rendered in our office to your insurance company. We feel all procedures in our office are medically necessary. However, some insurance companies in an attempt "to save cost" will consider some services as "non-covered" or "not-medically necessary." ANY services, which are denied, will be your responsibility.

AUTO ACCIDENTS / PERSONAL INJURIES / WORKER'S COMPENSATION

The patient MUST select which entity [*Health Insurance, Attorney, Party At Fault, Med Pay*] will be responsible for reimbursement of services rendered by the conclusion of the first visit.
Please direct questions regarding the selection to the Doctors during your consultation.

A signed lien is a requirement for treatment in our office. If you are dealing with an auto insurance company or involved in a lawsuit that affects the payment of the services rendered, please be advised that payment is due *NO LATER* than 90 days of discharge from our office, whether your case has settled. It is YOUR responsibility to stay on top of your case with the party at fault, auto insurance, and/or your attorney.

MEDICARE

We DO accept Medicare. Medicare members must pay for non-covered services at the time services are rendered. We will submit claims to Medicare, and they will submit to your secondary if you are setup on crossover. Please advise our staff if you are unaware if you are setup on crossover or not.

OVERDUE ACCOUNTS

Any patient portion unpaid after 90 days from the date of service will be subject to an 18% interest charge and risk of being sent to collections. I agree I will be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary.

NO SHOW / CANCELLATION FEES

We strive to provide care to our patients in a timely manner. If you are unable to give us a *FOUR HOUR* cancellation notice, you may be subject to a *$30 CANCELLATION* charge.

ASSIGNMENT OF BENEFITS

I have read and understand the above financial policy. I agree to assign insurance benefits whenever applicable. I also agree, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary. I understand that services rendered to me by CHAPEL, MCMURTRIE, & BARTLETT CHIROPRACTIC ORTHOPEDICS 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 CHAPEL, MCMURTRIE, & BARTLETT CHIROPRACTIC ORTHOPEDICS 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.*

I have been given the opportunity to pay my estimated deductible and coinsurance at the time of the service. I have chosen to assign 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 my insurance company. I authorize the provider to release any information necessary to adjudicate the claim.

I also understand that should my insurance company send payment to me, I will forward the payment to CHAPEL, MCMURTRIE, & BARTLETT CHIROPRACTIC ORTHOPEDICS within 48 hours.

I authorize CHAPEL, MCMURTRIE, & BARTLETT CHIROPRACTIC ORTHOPEDICS to initiate a complaint or 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 reduction or denials.

_____ _____

Patient Signature — Date

(if patient is minor, guardian or parent signature)

_____ _____

Witness Signature — Date