2018 UPDATE PATIENT INFORMATION

(ONE FORM PER FAMILY MEMBER PLEASE)

(PLEASE PRINT ALL INFORMATION)

(Fill out forms in Blue or Black ink only)

Name: _____ Date: _____/_____/_____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ / _____ / _____ Work Phone: _____ / _____ / _____

Cell Phone: _____ / _____ / _____ D.O.B: _____/_____/_____

I prefer to be contacted via: □ Home □ Work □□Cell

Email address: _____

APPOINTMENT REMINDER INFORMATION

We offer two forms of appointment reminders. PLEASE CHOOSE ONE OR BOTH
This is done thru a program called "Demand Force".

□Please email me my appointment reminders at: _____

□Please text me my appointment reminders at: _____

OPEN-DOOR POLICY:

I have read the Patient Authorization regarding chiropractic care being provided in an "open-door" adjusting environment and agree to this activity.

I have read and requested a copy, if desired, of the Privacy Practices.

X_____ _____/_____/_____

Patient Signature **Date**

NOTICE OF PRIVACY PRACTICES (HIPAA):

As required by the Health Insurance Portability and Accountability Act (HIPAA) we are required to give you a copy of the Notice of Privacy Practices for Healthy Life Chiropractic.

I have read and requested a copy, if desired, of the Privacy Practices.

Names and ages of all minors seen in our office:

_____

_____

_____

X_____ _____/_____/_____

Patient Signature **Date**

PLEASE READ, SIGN & FILL OUT ALL FIVE PAGES

PT # _____

HEALTHY LIFE CHIROPRACTIC STATEMENT OF OFFICE POLICIES

Welcome to Healthy Life Chiropractic. Please read and sign this policy statement below. Our staff will be happy to assist you with any questions or concerns you may have. We believe that a clear definition of our office policies will allow you, the patient, and Healthy Life Chiropractic to concentrate on the big issue—**REGAINING AND MAINTAINING YOUR HEALTH**.

CHIROPRACTIC, NEW PATIENT, UPDATE, RE-EST UPDATE, DECOMPRESSION, COLD LASER APPOINTMENT CANCELLATION POLICY & APPOINTMENT REMINDERS:
Appointments have been scheduled for your convenience, to minimize waiting and to facilitate incorporating these appointments into your daily routine. Regardless of how many appointments are scheduled for you each week, please note that it is the *frequency* of visits that counts, and not the days. We attempt to honor all appointments at the scheduled time. If you are late, you may have to wait for the next available appointment. If you have any questions regarding our office policy or your appointments, please do not hesitate to speak to the front desk assistant. We require a notice for any canceled or re-scheduled appointments. **Failure to show for any scheduled appointment including updates and exams without a 12 hour notification will result in a $45.00 charge payable by YOU, not your insurance company**. You are expected to re-schedule missed appointments in order to comply with your prescribed treatment plan. Please keep in mind that re-scheduling an appointment is always subject to availability. **Our office utilizes email and text to remind you of upcoming appointments.**

NEUROMUSCULAR RE-EDUCATION, REFLEXOLOGY AND ROF APPOINTMENT CANCELLATION POLICY AND APPOINTMENT REMINDERS:
Appointments have been scheduled for your convenience. Children are not allowed to be in the room during your appointment. **We require a 24 hour notice for any canceled or re-scheduled appointments**. **Failure to show for an appointment without notification will result in a $45.00 charge payable by YOU, not your insurance company**. **If at any time during the session the therapist is uncomfortable with your behavior during the session the therapist reserves the right to end the session and the full time allotted will be billed to you. Our office utilizes email and text to remind you of upcoming appointments for Massage and Reflexology.**

HEALTH RESPONSE TESTING, EAR CONING, IONIC FOOTBATH APPOINTMENT CANCELLATION POLICY AND APPOINTMENT REMINDERS:
Appointments have been scheduled for your convenience. **We require a 12 hour notice for any canceled or re-scheduled appointments. Failure to show for an appointment without notification will result in a $45.00 charge payable by YOU, not your insurance company**. **Our office utilizes email and text to remind you of upcoming Health Response Testing appointments.**

PRODUCTS SOLD IN THE OFFICE: All products that are sold in the office have a **NO RETURN POLICY**. (Supplements, Pillows, Oils, Back Supports, Bio-Freeze, Neck Collars, Foam Rollers & Sandals.) Orthotic can be returned to the company under Foot Levelers guidelines.

APPOINTMENT REMINDER: Healthy Life Chiropractic uses Demand Force program for our patient reminders and newsletters. You will receive a welcome letter via text message and or e-mail for you to opt-in or opt-out. If you choose to opt-out you will not be able to receive appointment reminders. **Please remember this can result in a $45.00 NO SHOW FEE if you opt-out and do not show up for your appointment**s.

FINANCIAL RESPONSIBILITY WITH AND WITH OUT INSURANCE:
Charges for treatment are due at the time the service is provided or a product is ordered.
Financial responsibility for services rendered rests with the patient regardless of any insurance coverage. It must be understood that your medical insurance is a contract between *you* and *your* insurance carrier. The benefits quoted by your insurance carrier are not a guarantee of payment and are subject to review based on the terms of your individual contract. Please note that you are responsible for knowing the limitations of your coverage. Your treatment plan is based on medical necessity as deemed appropriate by the doctor of Chiropractic Specialists or your referring physician. It is not our policy to enter into a dispute between you and your insurance carrier over any unpaid portion of your bill. Most insurance company's process claims within 15 days of receipt. If you have an HRA (Health Reimbursement Account) account it is your responsibility to keep up with your available HRA funds. If you have an HSA (Health Savings Account) you are responsible for your balance at the time of services rendered in the office.
NO SINGLE OR FAMILY ACCOUNTS WILL BE ALLOWED TO CARRY A BALANCE OVER $200.00.

STATEMENTS:
In an effort to reduce healthcare costs, it is the policy of HLC to mail as few statements as possible. HLC will email statements to the email address on file, if email is not available it will be sent postal mail. If a patient balance (due from patient) is incurred, responsible parties are encouraged to mail the payment directly to HLC upon receiving the EOB (explanation of benefits) from their insurance company. If 30 days after the generation of the first statement it is necessary for HLC to mail a second statement because no payment has been received an interest charge of a flat 12% of the balance, but not less than $5.00 will be added to the account. If no payment is received within 10 business days after the mail date of the second statement, the account will be reviewed and turned over to the collection agency. **ALL ACCOUNTS TURNED OVER TO THE COLLECTION AGENCY WILL ALSO BE RESPONSIBLE FOR THE COLLECTIONS AGENCY FEES OF 35% OF THE BALANCE OWED.**

RETURNED CHECKS:
There will be a **$40.00 fee** imposed for all checks returned to this office. All returned checks must be taken care of within 10 days of receipt. Any unpaid amounts after 10 days will be referred to our collection agency.

VOLUNTARY TERMINATION OF CARE:
It is also the policy of this office that if you should choose to suspend or terminate your care and treatment, any outstanding fees for professional services rendered to you will be **immediately due and payable**.

I, the undersigned, have read the Statement of Office Policies (above) and The Doctor-Patient Relationship in Chiropractic (on back) and I agree to abide by these policies.

Patient Name (Printed): X_____

Patient Name or Guardian (Signature): X_____ **Date:** _____ / _____ /_____

Pt. #: _____

DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC

CHIROPRACTIC
It is important to acknowledge the difference between the health and care specialties of Chiropractic, Osteopathy, and Medicine. Chiropractic health care seeks to restore health through natural means and without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the Chiropractic Physician's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from Chiropractic health care services.

ANALYSIS
A Chiropractic Physician conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation syndrome (VSS) or Vertebral Subluxation complexes (VSC). When such VSS or VSC complexes are found, Chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the Chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no physician can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSES
Although Chiropractic Physicians are experts in chiropractic diagnoses, the VSS and VSC, they are not internal medical specialists. Every Chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he has any concern as to the nature of his total condition. Your Chiropractic Physician may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE
A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the Chiropractic tests, diagnoses, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course will not give a chiropractic adjustment, or health care, if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known or learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the Chiropractic Physician. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Chiropractic Physician is licensed in a special practice and is available to work with other types of providers.

RESULTS
The purpose of Chiropractic services is to promote natural health through the reduction of the VSS or VSC since there are so many variables; it is difficult to predict the time schedule or efficacy of the Chiropractic procedures. Sometimes the response is phenomenal.
In most cases, there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same Chiropractic care. Many medical failures find quick relief through Chiropractic. In turn, we must admit that conditions which do not respond chiropractically may come under the control or be helped through medical science. The fact is that the science of Chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have great strides in alleviating pain and controlling disease.

I, the undersigned, have read the Statement of Office Policies (page before) and The Doctor-Patient Relationship in Chiropractic (above) as well as the CA has went over the Office Policies verbally with me and I agree to abide by these policies.

Patient or Guardian Signature: X_____ **Date:** _____ / _____ /_____

Pt. #: _____

Patients Name: _____ **Date**: _____/_____/_____

INSURANCE INFORMATION

Some Insurance policies have been affected with the following: United Healthcare and Aetna Insurance companies will not allow you to be adjusted, have neuromuscular re-education, and an exam in the same visit. If you would like to be adjusted in the same visit, you can do so by self-paying for your adjustment on that visit.

INSURANCE INFORMATION

Primary Insurance Company: _____ Policy Holder: _____

DOB: _____/_____/_____ Member ID#: _____ Group #: _____

SS#: _____-_____-_____
(Social Security # must be provided on all 3rd party accounts)

Home Phone #: _____-_____-_____ Cell #: _____-_____-_____

Relationship to the Policy Holder: _____

Secondary Insurance Company: _____ Policy Holder: _____

DOB: _____/_____/_____ Member ID#: _____ Group #: _____

☐ **I have no insurance or I have no insurance coverage therefore, I am self-pay**

PLEASE NOTE:

- **We must have a copy of your newest 2018 insurance card.**
- **Providing a copy of your newest insurance card even if it is last year's card this allows us to verify your 2018 chiropractic coverage to the best of our ability.**
- **Verifying your 2018 insurance allows us to quote your benefits in a manner that will save you the most money.**

Please note that if you are utilizing your insurance policy it is your responsibility to know your benefits including your deductible and the number of visits you have available. Your travel card will help with this. Should you have any questions or concerns please ask.
Initial: _____

Pt # _____

Insurance Authorization and Assignment

Patients Name: _____ **Date**: _____/_____/_____

Authorization to Release Information

I authorize the Doctor and their staff named below to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered and hereby release him/her of any consequence thereof. I agree that a Photostatic copy of agreement shall serve as the original.

X_____
Signature

Notice of Assignment

I hereby authorize and direct payment of any medical and surgical expense benefits allowable to the doctors named below as payment toward the charges for professional services rendered. This payment will not exceed my indebtedness the assignee. I agree that a Photostatic copy of this agreement shall serve as the original.

X_____
Signature

Notice of Insurance Payments

I understand that all insurance will be verified and billed directly from this office, although this is not a guarantee of payment. I also understand that if I should receive a check from my insurance company for services rendered in this office, I am to bring the check with a copy of the original explanation of benefits to our office so that my account will be accurate.

X_____
Signature

_____
Witness

Assignment and/or release authorization is granted to:
Healthy Life Chiropractic, Inc.

Pt. #:_____