

CHIROPRACTIC ACUPUNCTURE HEALTH CENTER
DR. CHERIE JOHNSON
NEW PATIENT CONFIDENTIAL INFORMATION
FILE # _____

Name: First _____ Nickname _____ MI _____ Last _____

Dependant child? _____ Parent/Guardian _____

Residential Address: _____

City _____ State _____ Zip _____

Same as mailing? If not, put mailing address here: _____

Home Phone: _____ Cell: _____ E-Mail: _____

Age: _____ DOB: _____ Social Security #: _____ Male/Female: _____

Marital Status: [] Single [] Married [] Divorced [] Widowed Referred by: _____

Employer: _____ Occupation: _____

Employer Address: _____ Work Phone: _____

SPOUSE OR GUARDIAN INFORMATION

Name: First _____ Nickname _____ MI _____ Last _____

Age: _____ DOB: _____ Social Security #: _____ Spouse/Guardian? _____

Employer: _____ Occupation: _____

Employer Address: _____ Work Phone: _____

CONSENT FOR EXAMINATION, X-RAYS CHIROPRACTIC SERVICE

- 1 I consent to have a complete examination performed to determine if my condition may be considered for chiropractic care.
- 2 I agree and understand that if it is so determined, clinic policy mandates that x-rays be taken of the area of involvement so a complete study and analysis of the area can be made. I understand that all such x-ray films taken by this clinic or films ordered elsewhere for this clinic, whether or not paid for by the undersigned patient, shall become a part of this clinic's professional records and shall be subject solely to the control and disposition of the clinic and their doctors. There will be a charge for copying x-rays if a request is made to transfer them to any other clinic or doctor by the patient or his representative.
- 3 I also give consent to the Doctors of Chiropractic Acupuncture Health Center, (CAHC), to administer whatever treatment or therapeutic procedure or device as deemed necessary to treat my condition.
- 4 I understand that the Doctors will go over my examination and x-ray results, during the follow-up appointment and explain the nature of condition, treatment recommendation, purpose of procedures, complication and risks, and allow time to answer any questions I might have. I acknowledge that no guarantee or assurance of the results of treatment can be given to me by the above attending Chiropractor, Associate or Assistants.

Signature: _____ **Date:** _____ **Witness** _____

FOR FEMALES ONLY: To the best of my knowledge I am not pregnant and the Doctors of Chiropractic Acupuncture Health Center have my permission to x-ray me for diagnostic interpretation. _____ (Initial)

FOR MINORS ONLY:

I hereby authorize the Doctors of Chiropractic Acupuncture Health Center to administer procedures, as outlined above, for my (indicate relationship), son/daughter /other. _____ (Initial)

Full name of child: _____

INSURANCE ASSIGNMENT POLICY

1. "Accepting Assignment" means billing the insurance company directly and waiting for the insurance company to pay us directly. We reserve the right to decide which insurance companies we will accept assignment for.
2. All insurance companies recite a disclaimer upon verification of benefits stating that although they will give us the benefits under your policy, it is not a guarantee of payment. We cannot guarantee payment from an insurance company until we have received the payment in office.
3. Claims are billed from our office on a 7-day cycle. Insurance claim processing can take anywhere from two to five weeks. There is a Quality of Insurance law that states "clean claims" must be paid within 45 days. If we do not receive payment within that period of time, a tracer will be sent. If insurance does not pay within 90 days, you will be responsible for that balance.
4. You must pay your deductible, co-payment, co-insurance and/or any non-covered charges at time of service. We recommend contacting your insurance to what your deductible for chiropractic services are since it may be different than your deductible for other physicians and services.
5. Your co-pay, co-insurance, and/or deductible amounts are determined by the information we receive from verifying your benefits online or by telephone. Amounts collected from you are based on this estimate. This may not be the exact amount that your insurance will cover--it depends on what the insurance company allows, and what fees they consider reasonable and customary. Not all insurance companies pay the same, even for identical charges. The fees we charge are UCR and do not vary or change. Fees are only discounted if we are a provider for an insurance carrier, i.e. Medicare and Blue Cross & Blue Shield. It is your responsibility to inquire as to whether or not we are a provider for your insurance carrier prior to services. At end of visit, service charges incurred are due and you will be responsible for your portion regardless of whether or not you knew we were or were not a provider.
6. You are required to sign an Assignment & Authorization form and any other documents that may be required by your insurance company on your initial office visit. We cannot treat you before all paperwork is completed, nor can we treat you while someone else completes paperwork for you. We make our paperwork available online so that your initial treatment can be as efficient as possible; you are informed that you may retrieve the paperwork from our website when you call to schedule your first appointment. **Our office does not guarantee that your insurance will pay.** We make every attempt to obtain accurate verification of benefits and coverage before you see the doctor on the initial visit. However, if your insurance claim is denied, you are responsible for the bill. Any balance due after insurance has paid will be your responsibility also. **Also, if you have an insurance policy that requires a pre-certification for treatment, we will not be responsible if your claim is denied because a pre-certification was not received. We also inquire about the need for a pre-certification when we confirm benefits over the phone. If we followed our office policy when checking for a pre-certification requirement and your insurance company still refuses to pay, that balance becomes your responsibility.** Your insurance coverage is a contract between you and the insurance company; it is your responsibility to know what a pre-certification is and when it is required. We bill your insurance company as a courtesy. The insurance information we use for you is given to us by your insurance company. Your policy is a contract between you and the insurance carrier, and benefit information given to us is not a guarantee of payment. Any disagreement or inaccurate information provided to us by your insurance company of a misunderstanding of your coverage is between you and your insurance company, and you are still responsible for payment of services not covered or not paid by your insurance company. Any denied services will be your responsibility.
7. I understand and agree that health/accident/workmen's comp. insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. Johnson will prepare any necessary reports and forms to assist me in making collection from insurance company and that any amount authorized to be paid directly to Dr. Johnson will be credited to my account upon receipt. **However, I clearly understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable. I understand that any late fees incurred because of an overdue account are my responsibility. I also understand that if my account is 90 days past due with no payments made it will be turned over to collections and subject to a 50% collection fee from our office. The collections agency may also attach a collection fee, which I will also be responsible for. I understand that if for any reason my account is sent to small claims court as opposed to a collections agency, I will owe the 50% collection fee plus any reasonable attorney fees. I hereby waive my rights of exemption under the state of Alabama and any other state. I understand that any unpaid balance will be subject to a \$5/week late fee charge after three statements have been mailed to me. Statements will be sent to the address on my account. Any change of address that is not reported is my fault and I am still responsible for the late fees that have incurred due to non-received statements.**

Patient Signature: _____ Date: _____

Chiropractic services provided in this office are payable the day services are rendered unless other arrangements have been made *prior* to seeing the doctor.

1. Patients are personally responsible for all charges.
2. Assignment will be accepted on primary carrier insurance only. Claims will be billed electronically on a weekly basis. Receipts will be given to patients so they can bill their secondary carriers. The only exception to this is if Medicare crosses over a Medicare supplemental policy electronically or if the secondary carrier is the only carrier that pays for Chiropractic Care; if not, the same rule applies. We do not accept assignment on third party liability claims, as they are non-assignable.
3. There will be a \$25 minimum charge for medical records requested by liability carriers, attorneys, and insurance application requests. There will be a \$5.00 charge for insurance claims forms that need to be completed that cannot be filed electronically and must be processed by hand or claims that have to be resubmitted more than twice.
4. Payment plans are available upon approval of credit extension by Office Manager. I authorize a credit check if credit is extended.
5. A late fee of \$5.00 per week will be added to an overdue account after three weekly statements are mailed. **Verification of eligibility and benefits from information carriers is not a guarantee of payment and the patient is ultimately responsible for all charges incurred.**
6. If an account is over 90 days past due with no payment activity (after insurance has paid or denied on assignment claims), the account will be placed for collection and a 50% collection fee based on the balance due will be added to the account, along with late fees incurred during the 90-day period. I agree to pay any costs of collection should this account become delinquent and reasonable attorney's fee and hereby waive my rights under the laws of the State of Alabama and any other state. I understand that any unpaid balance over 90 days will be subject to a collections fee of 50% and the late fees incurred during the 90 day period.

Patient Signature (If a minor, signature of guardian) _____ **Date** _____

Witness _____ Date _____

Nutritional Informed Consent

According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term "Drug" is defined to mean: *Articles intended for the use in the Diagnosis, Cure, Mitigation, Treatment, or Prevention of Disease. A vitamin is not a drug, NEITHER is it a mineral, Trace Element, Enzyme, Amino Acid, Herb or Homeopathic Remedy.* Although, a Vitamin, Mineral, Trace Element, Enzyme, Amino Acid, Herb, or Homeopathic Remedy may have an effect on the disease process or symptoms, this does not mean that it can be misinterpreted or classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as any primary treatment and/or therapy for any disease or particular body symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, or dietary advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patients diet in order to supply good nutrition supporting the physiological biochemical process of the human body.

Please acknowledge by signing below that you have read the afore mentioned and understand that any nutritional recommendations given to you by this office are nutritional recommendations and dietary suggestion's and are not for the treatment or care for any disease process that you may possess.

_____ **Patient signature/Date**

_____ **Witness signature/Date**

NOTICE OF MISSED APPOINTMENTS

Due to our increasingly busy schedule, any appointment that you miss will be subject to a \$25.00 Missed Appointment Fee. When we reserve the time for your appointment, we may be turning away other patients who want to be here. We ask that you cancel at least one hour before appointment time. I have read and fully understand that once I have missed an appointment without calling that I will be billed \$25.00, to be paid by myself and not my insurance company.

Signature: _____ **Date:** _____

NEW OFFICE POLICY REGARDING PATIENT ACCOUNTS

Due to the length of time it takes for insurance to send payments, misquoting of benefits by insurance companies, and because your insurance may not cover 100% of billable charges, **a credit card must be on file with our office**. We will automatically charge the card when one of the following:

- 1 Deductibles and co-payments are not paid when services are rendered
- 2 Patient terminates treatment plan
- 3 Patient does not abide by payment plan agreement
- 4 There has not been any payment made to an account within 30 days (3 statements)
- 5 Insurance does not cover all charges
- 6 Insurance will not pay for services

Patients are requested to be attentive by checking EOB statements sent by insurance--these statements show the amount your insurance has paid and are usually sent to patients before physicians.

Co-payments and deductibles must be paid at time of service. We will be more than happy to create payment plans at your request. All payment plans require a credit card and payments must be made continuously on the specified date or time. Please see the receptionist for more information concerning payment plans.

Payment policy and agreement				
Circle One:	Visa	MC	Discover	Debit
Account#:	_____			Expiration _____
Authorization signature	_____			

The Chiropractic Acupuncture Health Center is committed to maintaining the privacy of your protected health information (PHI), which includes information about you and the care and treatment you receive from us. Our office policy is to keep all information concerning our patients to the up-most confidentiality. Your credit card information will be guarded and used only when the above-mentioned criteria deems it necessary. For additional information regarding our policies please see the receptionist/office manager.

**PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION
TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS**

I hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The Practice’s Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the use and/or disclosure of my protected health information (“PHI”) necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice in accordance with applicable law.
3. I understand and consent to the following appointment reminders or communications that will be used by the Practice:
 - a) A postcard mailed to me at the address provided by me; and
 - b) Phone calls to my home and leaving messages on my answering machine or with the individual answering phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this consent is valid for **7 years**. I further understand that I have a right to revoke this Consent, in writing, at any time for all future transactions with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the use and disclosure(s) described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (Printed)

Signature of Individual

Signature of Legal Representative*

Relationship

Date Signed ____/____/____ **Witness:** _____

***Attorney-In-Fact, Guardian, Parent if a Minor**