We have prepared the following financial policy in order to help our patients determine their responsibility for payment of chiropractic and massage therapy services. Please check the box(s) that apply to you and sign the bottom.

Payment is expected at the time services are rendered.

□ **HEALTH INSURANCE** (Major Medical Coverage): Once insurance coverage is verified, we will be happy to bill your insurance company for you! You will be required to pay the amount not covered by your insurance company at each office visit.

- A telephone quote usually is the way we obtain medical benefit and eligibility information, however this does not necessarily mean your insurance company will approve treatment or guarantee payment of services.
- There is a possibility your insurance company has a deductible; if this pertains to you then it is your responsibility to pay for any portion that your insurance company does not cover. You can make arrangements to make payments for your deductible, co-payments and any other portion your insurance company does not cover.

□ **PERSONAL INJURY PROTECTION (PIP) and AUTO ACCIDENTS**: cases will be billed directly to the insurance company, provided paper has been filled out correctly and claim has been filed.

- If auto accident was not your fault you still must notify your insurance company so they are aware of the accident and can provide you with a claim number for your medical bills to be paid. This is a standard procedure with insurance companies; your insurance company will pay your medical bills up front and will be reimbursed from the at-fault company when your claim is settled.
- Even if the other insurance company agrees to pay for your medical bills, they have no obligation to them, and will exercise that right leaving you responsible for your medical bills.

□ **WORKERS COMPENSATIONS**: Workers compensation claims will be billed directly to the insurance company provided the paperwork has been filled out correctly and claims have been filed. IF YOU ARE DENIED WORKERS COMPENSATION, YOU WILL BE RESPONSIBLE FOR ALL BILLS INCURRED.

□ **MEDICARE**: Please be advised that Medicare-B will only pay for spinal adjustments and there is a 20% co-payment. THEY WILL NOT PAY FOR EXAMS AND X-RAYS.

□ **PRIVATE PAY:** If you do not have health insurance, you will be responsible for health care expenses and will make sure your accounts are kept current or have made payment arrangements that are suitable for all parties.

- OUR OFFICES "CASH" FEES ARE POSSIBLE DUE TO THE MINIMAL AMOUNT OF PATIENT BILLING REQUIRED. WE ASK THAT YOU PLEASE HAVE YOUR PLAN AMOUNT READY ON THE DATE IT IS DUE.
- We will be periodically be updating our accounts so if there is any discrepancy we will let you know right away so you can keep your account current. If you have a credit balance, we will inform you, at which time you can request a refund or leave the credit to be applied to the future charges.

We believe this is a clear definition of our financial policy and it will allow us all to continue to concentrate on the most important issue, your health and well-being. I have read and understand the above financial policy:

Signature:____ Date:_____________________________

WORKERS COMPENSATION QUESTIONNAIRE

Please answer all questions completely

Dear Patient: This information in considered confidential. We need this information because we care enough to want to know and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Name:___________________________Sex_____ Marital Status______ Date of Birth________Phone___________________ (Home Phone)

Address:______________________________City:_________________State:_________Zip:________________

Occupation:_______________________________Who referred you to our office?________________________

(Indicate if child, student, housewife, unemployed, retired)____

Social Sec #______________Business Phone_____________Company Name__________________Location________________________

Spouse's First name_______________Spouse's Soc. Sec. #________________Spouse's Employer_____________Location_______________

Please explain in detail how your accident happened:____

____

____

Have you retained an attorney? ___Yes ___No Litigation? ___Yes ___No ___Maybe

If so, name and address____

Give time and date present injury occurred________________ __AM __PM ____________20______________

Where did you feel pain immediately after the accident?____

Did you return to work? ___ Yes ___ No If so, date returned to work:_________________________________

Did you consult any other doctor? ___ Yes ___ No

If so, give doctor's name:___________________________ ___ D.C., ___ M.D., ___ D.O., ___D.D.S.

Doctor's diagnosis:____

What treatments did you receive? ____

Have you ever injured this area before? ___ Yes ___ No If so, when? ________________________________

If injured before, did you lose time from work? ___ Yes ___ NO

If you lost time from work with injuries prior to this injury, give name of doctor or doctors consulted:

____

Do any other diseases or accidents affect your employment? ___ Yes ___ No

If so, explain:____

____

In your work do you have to favor any part of your body? ___ Yes ___ No

If so, explain:____

Do you have a history of absenteeism caused from accidents on the job? ___ Yes ___ No

Have you ever had a Workers Compensation claim before before? ___ Yes ___ No

Before the injury were you capable of working on an equal basis with others your age? ___ Yes ___ No

Are your work activities restricted as a result of this accident? ___ Yes ___ No

Since this injury are your symptoms ___Improving? ___ Getting worse? ___ The same?

HEALTH QUESTIONNAIRE:

Please indicate for each of the questions below your experience by using the following codes:
1 - Never had, 2 – previously had, 3 – Presently have

MUSCULO-SKELETAL SYSTEM

__Low back problems
__Pain between shoulders
__Neck problems
__Arm problems
__Leg problems
__Swollen joints
__Painful joints
__Stiff joints
__Sore muscles
__Weak muscles
__Walking problems
__Ruptures
__Broken bones

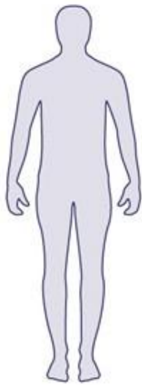
GENITO-URINARY SYSTEM

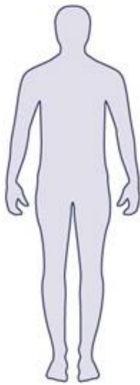
__Bladder trouble
__Excessive urination
__Scanty urination
__Painful urination
__Discolored urine

FEMALE

__Vaginal discharge
__Vaginal bleeding
__Vaginal pain
__Breast pain
__Lumps on breast
Are you pregnant?
__ Yes __ No

Please mark your areas of pain
On the figures below





GASTRO-INTESTINAL SYSTEM

__Poor appetite
__Excessive hunger
__Difficult chewing
__Difficult swallowing
__Excessive thirst
__Nausea
__Vomiting food
__Vomiting blood
__Abdominal pain
__Diarrhea
__Constipation
__Black stool
__Blood stool
__Hemorrhoids
__Liver trouble
__Gall bladder problems
__Weight trouble

NERVOUS SYSTEM

__Numbness
__Loss of feeling
__Paralysis
__Dizziness
__Fainting
__Headaches
Muscle jerking
__Convulsions
__Forgetfulness
__Confusion
__Depression

CARDIO-VASCULAR RESPIRATORY

__Chest pain
__Pain over heart
__Difficult breathing
__Persistent cough
__Coughing phlegm
__Coughing blood
__Rapid heartbeat
__Blood pressure problem
__Heart problem
__Lung problem
__Varicose veins

EYE, EAR, NOSE, AND THROAT

__Difficult speech
__Eye strain
__Eye inflammation
__Vision problems
__Ear pain
__Ear noises
__Hearing loss
__Ear discharge
__Nose pain
__Nose bleeding
__Difficult breathing thru nose
__Sore gums
__Dental problems
__Sore mouth
__Sore throat
__Hoarseness

DO NOT WRITE BELOW THIS LINE ______________________________________**Patient's Signature**

____

____

____

Patient accepted? __ Yes __ No Doctor's Signature:____

HIPPA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act [HIPPA] provides safeguards to protect your privacy. Implementation of HIPPA requirements officially began on April 14, 2003. Many of the policies have been *our* proactive for years/ this form in a "friendly" version. A more complete text is posted in the office. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information [PHI]. These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPPA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov
We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide serves or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may not do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspection of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions into the use of you protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies tic inform your request.

I, ____date_______________________do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care. It is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. It will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal, physical, mental and social well being, not merely the absence of the disease or infirmity.

Vertebral Subluxations: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer diagnosis or treat any disease or condition other than vertebral subluxations. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate interference to the expressions of the body's innate wisdom. Out only method is specific adjusting to correct vertebral subluxations.

I,____________________________, have read and fully understand the above statement.

(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_________________________________ _______________________

(Signature) (Date)

AUTHORIZATION FOR RELEASE OF X-RAYS AND RECORDS

I authorize any doctor, hospital, employer, insurer, or other person, to whom a signed, original or photocopy of this authorization is delivered, to furnish any information, reports, or copies of records or radiological information, which may be requested to East Vancouver Chiropractic. This authorization shall remain valid for one year from the date signed.

______________________________ ______________________________

Social Security Number **Date of Birth**

______________________________ ______________________________

Signature **Date Signed**