

# CONFIDENTIAL PATIENT HISTORY

Date \_\_\_\_\_

Name (including middle initial) \_\_\_\_\_

Male  Female  Marital Status: M S W D O

Address \_\_\_\_\_ No. of Children \_\_\_\_\_

City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_ Social Security Number \_\_\_\_\_

Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Email Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_ Work Phone \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Spouse Social Security Number \_\_\_\_\_

Spouse Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Name of Your Insurance Company \_\_\_\_\_

Name of Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

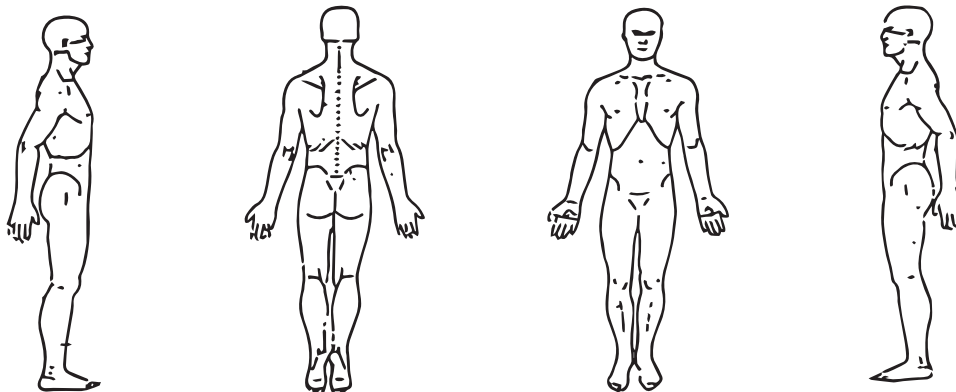
*(Nearest relative or friend, not spouse)*

How do you prefer to be verbally addressed? \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Present Complaint \_\_\_\_\_

**MARK ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. INCLUDE SYMPTOMS OF PAIN, NUMBNESS OR TINGLING, ETC.**



**Patient Name** \_\_\_\_\_ **Date:** \_\_\_\_\_

When did your problem begin? Specific date if possible \_\_\_\_\_

How did your problem begin? \_\_\_\_\_

\_\_\_\_\_

In the past have you had anything similar to this?  YES  NO Please explain \_\_\_\_\_

\_\_\_\_\_

Please describe the character of your current pain. You may check one or more answers.

- Sharp  Stabbing  Burning  Shooting  Aches  Soreness  
 Weakness  Throbbing  Numbness  Dull  Constricting  Stiff  
 Other \_\_\_\_\_

On a Scale from 0-10, with 10 being the worst pain you have experienced and 0 being no pain.

What is your current scale of pain? 0 1 2 3 4 5 6 7 8 9 10

How often are the complaints present?

- Constant/100% of time  Frequent/75%  Intermittent/50%  Occasional/25%

Comments: \_\_\_\_\_

Is the pain:  Increasing  Decreasing  Not Changing  Varies

Pain is aggravated by:  Walking  Sitting  Standing  Riding in a car  Lifting  
 Bending  Stretching  Twisting  Running  Transitioning from seated to standing  
 Other \_\_\_\_\_

Pain is reduced by:

- Medicine  Exercise  Rest  Physical Therapy  Supplements  
 Other \_\_\_\_\_

What would you like to do, but can't, because of your pain? \_\_\_\_\_

\_\_\_\_\_

Are your complaints, in any way, affecting your ability to work or be active?

- No effect  Some physical restrictions  Unable to perform regular duties

Is there any dizziness associated with symptoms?  YES  NO

Any fever or chills?  YES  NO

Any change in bowel or bladder (bathroom) function?  YES  NO

Are your complaints affecting your ability to sleep?  YES  NO Explain: \_\_\_\_\_

On average, how many hours of sleep do you get per night? \_\_\_\_\_

Do you sleep through the night uninterrupted?  YES  NO

How do you rate your overall health?  Excellent  Good  Fair  Poor

For your present complaint have you seen any other doctors or had any physical therapy?  YES  NO

If yes, who? \_\_\_\_\_ What treatment? \_\_\_\_\_

**Patient Name** \_\_\_\_\_ **Date:** \_\_\_\_\_

FAMILY DOCTOR/PRIMARY CARE PHYSICIAN \_\_\_\_\_

*We normally keep your family doctor and/or referring physician informed regarding your care at this office.*

Is that okay?  YES  NO Please specify name and address: \_\_\_\_\_

## MEDICAL HISTORY

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Anemia  | <input type="checkbox"/> Depression         | <input type="checkbox"/> Respiratory Problems   |
| <input type="checkbox"/> Arthritis   | <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Asthma <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled   |
| <input type="checkbox"/> Cancer  | <input type="checkbox"/> Fractures          | <input type="checkbox"/> COPD <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled     |
| <input type="checkbox"/> Cardiovascular Problems   | <input type="checkbox"/> Headaches          | <input type="checkbox"/> Seizures   |
| <input type="checkbox"/> Holter Monitor-currently wearing?   | <input type="checkbox"/> Hepatitis/HIV      | <input type="checkbox"/> Thyroid Problems   |
| <input type="checkbox"/> Pacemaker   | <input type="checkbox"/> Kidney Problems    | <input type="checkbox"/> Diabetes <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled |
| <input type="checkbox"/> Currently Pregnant  |   | <input type="checkbox"/> Other  |
| <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled  |   |   |
| <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled |   |   |

If you checked any above, please explain: \_\_\_\_\_

Have you missed any days of work or school due to the current condition?  YES  NO Dates missed: \_\_\_\_\_

Have you **ever** broken any bones?  YES  NO Explain: \_\_\_\_\_

Have you been in the hospital or had surgery for **any** reason?  YES  NO

Please explain: \_\_\_\_\_

Have you ever been in an accident?  YES  NO Please explain: \_\_\_\_\_

What Supplements are you taking? \_\_\_\_\_

Consume alcohol?  YES  NO How Much: \_\_\_\_\_

What is your exercise routine? \_\_\_\_\_

Other health concerns: \_\_\_\_\_

Patient Name \_\_\_\_\_ Date: \_\_\_\_\_

# EHR INFORMATION

Smoking Status:     Every Day Smoker     Occasional Smoker     Former Smoker     Never Smoked

Are you currently taking any medications? Please include all prescription and non-prescription. (e.g. Ibuprofen, Tylenol, Aleve)

Medication Name	Dosage and Frequency (i.e. 5mg per day, etc.)

Family Medical History (Record one diagnosis in your family history and the affected relative)

Diagnosis (Write in below)	Father	Mother	Sibling	Offspring

Preferred Language \_\_\_\_\_

Patient Name \_\_\_\_\_ Date: \_\_\_\_\_

## NATURE OF THE ACCIDENT

Date of Accident \_\_\_\_\_ Time of Day \_\_\_\_\_ Were you  Driver  Passenger  Front Seat  Back Seat

In your own words please describe the accident: \_\_\_\_\_

Were you working, on work time, or was driving associated with business at the time of the accident?  Yes  No

Number of people in your vehicle? \_\_\_\_\_ Were you wearing seat belts?  Yes  No

Were you wearing a hat or glasses?  Yes  No If yes, still on after crash?  Yes  No

What street were you traveling on? \_\_\_\_\_

What street was the other vehicle traveling on? \_\_\_\_\_

Were you struck from:  Behind  Front  L. Side  R. Side What state did the accident happen in? \_\_\_\_\_

Approx. speed of your car \_\_\_\_\_ MPH other car \_\_\_\_\_ MPH

Were you knocked unconscious?  Yes  No If yes, for how long? \_\_\_\_\_ Were Police notified?  Yes  No

Were you taken to a hospital emergency room? \_\_\_\_\_

Please describe how you felt:

a. IMMEDIATELY AFTER the accident: \_\_\_\_\_

b. LATER THAT DAY: \_\_\_\_\_

c. THENEXTDAY: \_\_\_\_\_

Were you aware of approaching collision prior to impact, or did it take you by surprise? \_\_\_\_\_

How far is the headrest or seat back from the back of your head? (Approximately) \_\_\_\_\_

Was the seat back adjustment altered by the accident?  Yes  No Was the seat broken?  Yes  No

Did an air bag deploy?  Yes  No If yes, were you struck?  Yes  No

What is the make, model and year of your vehicle? \_\_\_\_\_

What is the make, model and year of the other vehicles involved? \_\_\_\_\_

Did the windshield break during the accident? \_\_\_\_\_

At the time of impact, which direction were you looking? \_\_\_\_\_

How do you rate your overall health?  Excellent  Good  Fair  Poor

**Patient Name** \_\_\_\_\_ **Date:** \_\_\_\_\_

What were the road conditions at the time of the accident?  Wet  Dry  Icy  Other \_\_\_\_\_

Have you missed any days of work or school due to the injury?  Yes  No If yes, please list days: \_\_\_\_\_

\_\_\_\_\_

Other pertinent information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## INSURANCE INFORMATION

YOUR Car Ins. Co \_\_\_\_\_ Phone# \_\_\_\_\_

Adjuster \_\_\_\_\_ FAX# \_\_\_\_\_

Claim# \_\_\_\_\_ Name on Policy (if other than self) \_\_\_\_\_

Your Major Medical Ins. Co \_\_\_\_\_ ID# \_\_\_\_\_

Were you at fault?  Yes  No If someone else was at fault, their name \_\_\_\_\_

## ATTORNEY INFORMATION

Have you contracted with an attorney?  Yes  No

Name of Attorney \_\_\_\_\_

Attorney Firm \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone# \_\_\_\_\_

Were there any witnesses?  Yes  No Their Name(s) \_\_\_\_\_

# INFORMED CONSENT FOR CHIROPRACTIC CARE

**CHIROPRACTIC EXAMINATION AND TREATMENT** On occasion, some patients experience increased discomfort following chiropractic care and examination. Chiropractic physical examination and treatment may involve bending and physically challenging joints and soft tissues (e.g. muscles and ligaments) of the spine and extremities, and it can possibly lead to temporary feelings of soreness or pain. During treatment, the Doctor of Chiropractic may use their hands or mechanical devices to move, adjust, or manipulate joints and mobilize soft tissues. With certain soft tissue therapies, light to moderate bruising may also occur. This is nearly always a temporary issue that occurs while the area under care is undergoing therapeutic change. Patients reserve the right to consent to, or refuse, certain aspects of care once therapeutic options have been presented.

**RISKS OF CHIROPRACTIC CARE AND TREATMENT** I understand and have been informed that there are risks of side effects and complications anytime a healthcare provider is asked to intervene in an encounter with a patient. I have been informed of the following: that although the risk of serious complications from chiropractic treatment are rare and unlikely, events ranging from soreness, sprains and strains, to fracture or dislocation, to injuries of the spinal discs, nerves and cord have occurred. Cerebrovascular accidents, such as a stroke, have also been reported and that these have been estimated to occur in 1 in 2 million to 1 in 3.8 -5.8 million cervical manipulations, about the same probability of stroke occurring from turning your head or having your hair washed in a salon ("beauty parlor stroke"). It cannot be said with any certainty that the specific treatment caused the stroke or aggravated an underlying, pre-existing condition, or the treatment given was totally unrelated to the resulting stroke. You are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with cervical adjustment or manipulation is extremely remote.

I understand and I do not expect the Doctor of Chiropractic to be able to anticipate all the potential risks or complications. There may be problems or complications that might arise from treatment and recommendations other than those noted. These other events or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

I wish to rely on the Doctor of Chiropractic to exercise their best professional judgment during the course of the chiropractic examination and treatment, which the doctor feels is in my best interest, based upon the facts as then known at the time.

I will immediately notify a member of the office staff of any unanticipated side effects or adverse reactions associated with treatment. I also understand that if I become concerned about any post-treatment discomfort or, if I should develop any new or unrelated symptoms, I should call the practice for immediate attention. I also understand that if, for some reason, I am unable to reach or contact the practice, that I should telephone my personal primary care doctor or present myself to the nearest hospital emergency room.

**ALTERNATIVE TREATMENTS AVAILABLE** I understand that there are reasonable alternatives to treatment including, but not limited to: rest, home application of therapy, prescription or over-the-counter medication, exercise, non-treatment, treatment and evaluation by another provider, and surgery. Each is associated with their own benefits and risks. I have the right to request a referral to another provider for further evaluation, assessment, and management of my presenting condition(s) at any time.

**CONSENT** By affixing my signature below, I acknowledge that I have read and understood the above consent and have had the opportunity to ask questions about its content and meaning, if so desired, which have been answered to my satisfaction, **PRIOR TO MY SIGNING OF THIS CONSENT FORM.**

**I, the undersigned, hereby request, consent to, and authorize Mt. Lookout Chiropractic & Sports Injury Center to conduct physical examinations, perform testing procedures as are required, and administer treatment as deemed necessary or advisable for my presenting complaint(s) that are within the scope of the practice of chiropractic care. I attest that the information provided in regards to my, or my dependents, current and past health history has been completed to the fullest extent and to the best of my knowledge and ability, and does not contain false or misleading information, nor omission. I also certify that no guarantee or assurance has been made to me as to the results that may be obtained from any treatment rendered.**

**I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek examination and treatment for myself or my dependent.**

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Signature (Patient, Parent, or Legal Guardian)

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Print Name (Patient, Parent, or Legal Guardian)

## **PRIVACY PROTECTION AND AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: plan, coordinate, and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and accreditation. This includes release of information and notification of care to my primary health care and/or referring provider.

I hereby authorize Mt. Lookout Chiropractic & Sports Injury Center to release a complete report of services rendered including diagnosis, findings and details of treatment, and progress for the purpose of receiving payment for the services rendered to its authorized billing agents, my insurance carriers, employer's workers compensation insurance company, or other category of third party payers, the Social Security Administration under Title XVIII (18) of the Social Security Act, any Professional Review Organization, attorney, or other intermediaries responsible for payment of my charges and hereby release Mt. Lookout Chiropractic & Sports Injury Center from any consequences thereof. I understand that I may revoke this consent at any time by giving written notice.

Please list below the names of and your relationship to individuals whom you authorize Mt. Lookout Chiropractic & Sports Injury Center to release your protected health information.

### **Name and Relationship**

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## **ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have been provided a copy of the Notice of Privacy Practices and that I have read or declined the opportunity to read and understand the Notice of Privacy Practices. I understand that these privacy practices will be followed by Mt. Lookout Chiropractic & Sports Injury Center to ensure the privacy of my protected health information. I understand that this acknowledgement will be placed in my electronic file and maintained for six years. A copy of this notice is available at any time upon request.

## **AUTHORIZATION TO ACQUIRE HEALTHCARE INFORMATION**

I hereby authorize Mt. Lookout Chiropractic & Sports Injury Center to obtain details regarding my current and/or prior health care status from my primary care provider, referring

provider, and/or other providers to facilitate appropriate care. All health records, diagnostic imaging results, diagnostic testing results, surgical information, and any data that are held regarding my medical and health management are applicable for release. This release does NOT allow information pertaining to drug and/or alcohol abuse, or mental health information to be included. I understand that I may revoke this consent at any time, except to the extent that action has already been taken, with written notice.

## **ASSIGNMENT OF INSURANCE BENEFITS AND FINANCIAL POLICY**

In consideration of all services provided, I hereby assign and transfer to Mt. Lookout Chiropractic & Sports Injury Center all of my rights, title, and interest to healthcare reimbursement in accordance with the terms and benefits under my insurance policy or other health benefits otherwise payable to me for those services rendered, including Medicare Part B. I certify that the health insurance information that I have provided is accurate and that I am responsible for keeping it updated.

I understand that I will be fully responsible for payment of any and all charges not paid by health insurance. I understand that the balance of my account is due in full within 30 days of notice, unless a payment plan arrangement has been made in advance. In the event that a bill is disputed, notification must be made within 30 days. If I do not notify Mt. Lookout Chiropractic & Sports Injury Center within that time, the bill will be presumed valid and due. All balances remaining unpaid after 30 days may be reported to a collection agency, and I will be responsible for all collection expenses including reasonable attorney's fees and court costs.

I hereby authorize Mt. Lookout Chiropractic & Sports Injury Center to submit claims, on my or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I have provided, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Mt. Lookout Chiropractic & Sports Injury Center directly for services rendered to me or my dependent.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Mt. Lookout Chiropractic & Sports Injury Center are paid in full. I also understand that I am responsible for all amounts not paid by my health insurance, including co-payments, co-insurances, and deductibles.

Mt. Lookout Chiropractic & Sports Injury Center accepts cash, personal check, Visa, Discover, and MasterCard. I understand that I will have to pay a \$30.00 fee for each check that is returned to Mt. Lookout Chiropractic & Sports Injury Center for non-sufficient funds.

Prior balances considered delinquent must be paid prior to being seen for any further scheduled visits. Charges added to your account will be due in full when stated on the invoice.



## ERISA AUTHORIZATION (EMPLOYEE RETIREMENT INCOME SECURITY ACT)

I hereby designate, authorize, and convey to Mt. Lookout Chiropractic & Sports Injury Center to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. (2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from Mt. Lookout Chiropractic & Sports Injury Center and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

## NOTICE OF OFFICE PROCEDURES AND COMMUNICATIONS

Many areas of our office are an open concept. While we do our best to discuss information regarding your treatment and/or accounts privately, at times other patients may be able to overhear. We ask that if you would like to discuss something more privately that you let us know.

Communications from our office including but not limited to, patient bills, letters, thank you cards, and claims sent to insurance companies are all sent out in envelopes with our office name on them.

It is the policy of Mt. Lookout Chiropractic & Sports Injury Center to not leave messages via voicemail, e-mail, or with another party regarding your care, testing results, specific follow up instructions, or other situations involving your personal health or care provided in this office or elsewhere. When needed, communications will be limited in scope and nature with as little identifying or specific information as possible, often requesting a return phone call to discuss pertinent information. However, with your consent, detailed information can be left via the following methods:

I hereby authorize that Mt. Lookout Chiropractic & Sports Injury Center can leave detailed messages regarding my healthcare. **Please check all that apply.**

Cell  Home  Work  Email

I hereby authorize that Mt. Lookout Chiropractic & Sports Injury Center can leave detailed messages regarding my healthcare via another person reached at the following phone numbers that I have provided:

Cell  Home

I, the undersigned, hereby certify that I have read, fully understand, and agree to be bound by these policies, assignment, and authorization pertaining to myself or my dependent. I have asked or have declined the opportunity to ask any pertinent questions regarding this information before applying my signature. A photocopy of this document shall be considered as effective as the original. I intend this certification to cover the entire course of treatment for my present condition and for any future conditions for which I seek examination and treatment for myself or my dependent.

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Signature (Patient or Responsible Party)

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Print Name (Patient or Responsible Party)

---

Date

## CONSENT TO TREAT A MINOR WITHOUT PARENT OR GUARDIAN PRESENT

I do hereby authorize and give my consent to Mt. Lookout Chiropractic & Sports Injury Center to provide evaluation and treatment as needed and necessary to my minor child in my absence following initial consultation.

Yes  No

My child will be accompanied by (check all that apply):

Himself or Herself

Other: \_\_\_\_\_

Other: \_\_\_\_\_

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Signature (Parent or Responsible Party)

# SCHEDULE OF TREATMENT FEES

CPT CODE	DESCRIPTION	CHARGE	CPT CODE	DESCRIPTION	CHARGE
<b>NEW PATIENT E&amp;M</b>			<b>MISCELLANEOUS</b>		
99201	PROB. FOC. STRTFWD.	60	99080	NARRATIVE	150
99202	EXPANDED STRTFWD.	110		DEPOSITION 1st HR. DUE PRIOR TO	400
99203	DETAILED LOW COMPLX.	125		DEPOSITION EA. ADDL. ¼ HOUR	100
99204	COMPRES. MOD. COMP.	175	<b>PROCEDURE</b>		
<b>ESTABLISHED PATIENT E &amp; M</b>			98940	SPINAL 1-2 REGIONS	60
99211	LOW COMPLEXITY	45	98941	SPINAL 3-4 REGIONS	70
99212	PROBLEM FOC.STRTFWD	50	98943	EXTRASPINAL, 1+REGION	45
99213	EXPANDED LOW COMP.	75	<b>THERAPY</b>		
99214	DETAILED MOD. COMP.	125	97035	ULTRASOUND	22
99215	COMPREHENSIVE HIGH	175	97014	UNATTENDED ELEC. STIM	23
99456	INDEPEND. MEDICAL EX.	300	97010	HOT OR COLD PACKS	17
<b>X-RAY DIAGNOSTIC STUDIES</b>			97110	THERAPEUTICS EXERCISES	45
72040	CERVICAL 2-3 VIEWS	60	97112	NEUROMUSCULAR RE-ED	45
72050	CERVICAL COMP. 4 VIEWS	100	97012	TRACTION/MECHANICAL	32
72052	CERVICAL 5-7 VIEWS	140	97140	MANUAL THERAPY TECHNIQ.	28
72070	THORACIC 2 VIEWS	60	97530	THERAPEUTIC ACTIVITIES	45
72020	THORACIC SPINE 1 VIEW	60	<b>ORTHOPEDIC SUPPORTS</b>		
72100	LUMBAR LIMITED	80	99070	LUMBAR PILLOW	48
72020	LUMBAR SPINE, 1 VIEW	60	E0230	COLD PACK SMALL	12
72020	L-5 SPOT VIEW	60	E0230	COLD PACK HALF SIZE	22
72114	LUMB. COMP. 2/BENDING	100	E0230	COLD PACK FULL SIZE	30
72110	LUMBAR W/OBL. 4 VIEWS	80	E0230	COLD PACK CERVICAL	30
72170	PEL VIS 1 view (AP)	60	E0943	CERV. SUPPORT PILLOW	40
73030	SHOULDER 3 VIEWS	60	L0515	LUMBOSACRAL SUPPORT	45
76140	WRITTEN X-RAY REPORT	varies	L3332	HEEL LIFT	5
	<b>EXTREMITY VIEWS</b>		L3700	ELBOW WRAP(TENNIS EL.BR.)	10
	Elbow	80	L3908	WRIST SUPPORT	25
	Forearm	80			
	Wrist	80			
	Hip 2 views	100			
	Hip 1 view	60			
	Knee	80			
	Ankle	80			
	Foot	80			

*A photocopy of this document will be treated as an original*

\_\_\_\_\_  
(SIGNATURE OF PATIENT)

\_\_\_\_\_  
(DATE)

\_\_\_\_\_  
(PRINT PATIENT NAME)

# HIPAA Authorization Form

## Authorization for Use or Disclosure of Information

I, \_\_\_\_\_, hereby authorize **Mt. Lookout Chiropractic and Sports Injury Center** to (check those that apply):

- use the following protected health information, and/or
- disclose the following protected health information to:

\_\_\_\_\_  
Please list the name of one person or company

This protected health information is being used or disclosed for the following purposes: **All medical records, financial information including charges and reports. All established medical records and future records as created by Mt. Lookout Chiropractic Center.**

This authorization shall be in force and effect until: \_\_\_\_\_  
at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to Tawnya Dupuy at **Mt. Lookout Chiropractic and Sports Injury Center, 455 Delta Ave. Cincinnati, Ohio 45226**. I understand that a revocation is not effective to the extent that **Mt. Lookout Chiropractic and Sports Injury Center** has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

**Mt. Lookout Chiropractic and Sports Injury Center** will not condition my treatment, payment, or enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.

The use or disclosure requested under this authorization will result in direct or indirect remuneration to the **Mt. Lookout Chiropractic and Sports Injury Center** from a third party.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Representative

\_\_\_\_\_  
Authority of Representative

# EXTENDED FINANCIAL POLICY

Please read our financial policy in its entirety. If you have any questions or concerns please feel free to ask any questions that you may have. Your clear understanding of our Patient Financial Policy is important to our professional relationship.

**INSURANCE** It is the patient's responsibility to provide our office with current insurance information. We will ask for your insurance card at your first visit and will copy for our records. We will request a copy at each annual office visit, or if you have not been seen in the past six months. If your insurance information changes at any time during your treatment, it is ultimately your responsibility to provide us with the new information as soon as it becomes active. If current information is not obtained at the time of service it will be the patient's responsibility to pay the entire balance until current information is provided to our office. It is the patient's responsibility to know their benefits and coverage.

Your insurance policy is a contract between you and the insurance company. As a courtesy and pursuant to contractual obligations we will file all your claims for you. However, we will not become involved in any disputes between you and your insurance carrier. This includes, but is not limited to, deductibles, copays, and non-covered charges.

**REFERRALS** Some insurance policies require you as the policy holder to obtain a referral from your primary care physician, or student health center prior to receiving treatment at our office. It is your responsibility to obtain this documentation and present it to our office at the time of service. If this information is not obtained, you will be responsible for the entire balance of your account.

**COPAYS** Copays are due at the time of service. Copays are usually collected PRIOR to you seeing the doctor but may sometimes be collected after you have received treatment.

*\*\*If your copay is not paid at the time of service you will be charged a \$15 service fee to cover the cost of billing you for the copay.*

**MEDICARE** If you are a Chiropractic Medicare patient you will be responsible to pay for your exam on your first visit, at the time of service. While Medicare requires an exam they do not cover it. Exams are typically \$100. Xrays are also not covered by Medicare and the cost would be your responsibility and would also be due at the time of service.

**CASH PLANS** Cash plans are available for patients who do not have insurance or wish to not bill to insurance. These plans differ and can be discussed with your doctor. Cash plan payments are due at the time of service.

*\*\*If payment is not made at the time of service a \$15 service fee will be charged to cover the cost of billing you for the charges.*

**SUPPLEMENTS/MERCHANDISE** Payments for supplements and merchandise purchased in our office are due at the point of sale. We cannot bill insurance, worker's compensation, or personal injury accounts for these items. These charges are the patient's responsibility and are not covered by any insurance carrier. These items include but are not limited to, swiss balls, dvds, supplements, water pillows, back packs, braces, heel lifts, orthotics, and cold packs.

**UNPAID/OUTSTANDING BALANCES** We ask that full payment be made at the time of service unless prior arrangements have been made, either with your doctor or our billing office. If you have a deductible plan, once insurance has paid you will be mailed a statement: Prompt and timely payment is appreciated. You may call our billing office to set up a payment plan if necessary. Any overdue balances will be considered for collections.

**RETURNED CHECKS** The charge for a returned check is \$30. This can be paid by cash, money order, or charge. This will be applied to your account in addition to the original amount owed.

**MISSED APPOINTMENTS** We ask that you keep all scheduled appointments. In the event that you are unable to keep your appointment we ask that you provide at least a 4 hour notice for Chiropractic appointments and 24 hours for Physical Therapy. A \$35 missed appointment fee may apply for Physical Therapy appointments.

**CREDIT BALANCES** From time to time you may accrue a credit balance. Credit balances will be refunded at the patient's request. Refunds are made by check. After the request for a refund has been made, please allow time for review of your entire account and processing through our accounting department. Once approved please allow 30-45 days for your refund check to arrive.

**I have read Mt. lookout Chiropractic and Sports Injury Center's Patient Financial Policy and acknowledge my responsibility with my signature below.**

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Signature (Patient, Parent, or Legal Guardian)

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Print Name (Patient, Parent, or Legal Guardian)

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MLC Staff Witness

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Date

\*A photo copy of this document will be treated as an original\*

## PATIENT HEALTH INSURANCE VERIFICATION

**CHECK EVERY BOX THAT IS TRUE:**

- I will be filing through Med-Pay through my car insurance.
- I do not have health insurance that will cover my treatment for my injuries.

**IF PATIENT HAS HEALTH INSURANCE CHECK ONLY ONE OF THE TWO FOLLOWING BOXES:**

- I don't want my health insurance to be billed for treatment of my injuries, **except** if my car insurance requires it before I can use my medical payments coverage in my car insurance. These are some of my reasons:

I don't want to pay health insurance co-payments. I don't want the potential obligation to have to pay this Clinic for treatment which is not covered by my health insurance.

I do not want to use up any of my annual visit limitations for my health insurance for this treatment which has been caused by an accident.

- The Clinic is under contract as a provider for my private health insurance, or I am covered by Medicare, Medicaid or other government sponsored health insurance. I authorize this Clinic to bill my health insurance for all covered services. I understand that I may be required to pay co-payments at the time of service.
- I understand and agree that all services and charges of this Clinic not covered by my health insurance will be paid by myself, the policy holder.

\_\_\_\_\_  
(Signature of Patient, Parent or Legal Guardian)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Print or type above name)

\_\_\_\_\_  
(Staff Witness)