Mt. Lookout Chiropractic
& Sports Injury Center

455 DELTA AVE., SUITE 1
CINCINNATI, OH 45226
(513) 321-8484

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)

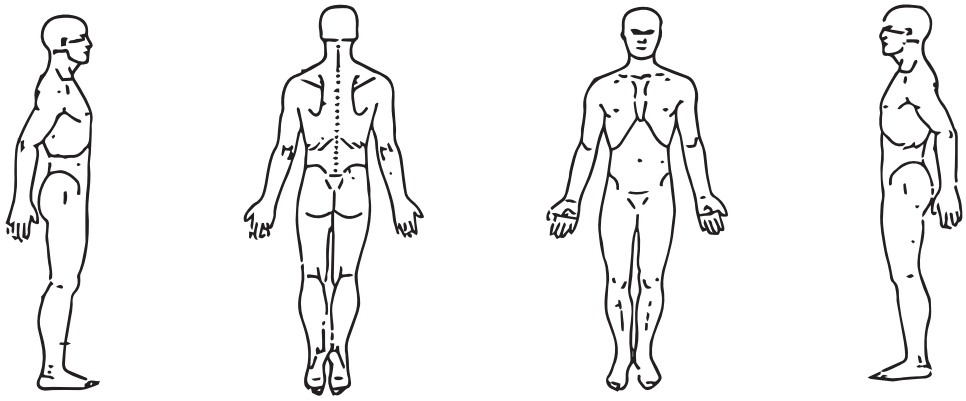
How do you prefer to be verbally addressed? _____

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 I 2 3 4 5 6 7 8 9 I0

How often are the complaints present?
☐ Constant/IOO% 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

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

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 ofthe 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. IMMEDIATLY 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 ofyour 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 ofthe 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 ofthe accident? ☐ Wet ☐ Dry ☐ Icy ☐ Other _____

Have you missed any days ofwork 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.

_____

Signature (Patient, Parent, or Legal Guardian)

_____

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

_____

_____

_____

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.

_____

Signature (Patient or Responsible Party)

_____

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:** _____

_____

Signature (Parent or Responsible Party)

Mt. Lookout Chiropractic
& Sports Injury Center

455 DELTA AVE., SUITE 1
CINCINNATI, OH 45226
(513) 321-8484

SCHEDULE OF TREATMENT FEES

CPT CODE	DESCRIPTION	CHARGE
	NEW PATIENT E&M	
99202	EXPANDED STRTFWD.	110
99203	DETAILED LOW COMPLX.	125
99204	COMPRE. MOD. COMP.	180
	ESTABLISHED PATIENT E & M	
99212	PROBLEM FOC.STRTFWD	50
99213	EXPANDED LOW COMP.	75
99214	DETAILED MOD. COMP.	125
99215	COMPREHENSIVE HIGH	175
99456	INDEPEND. MEDICAL EX.	300
	X-RAY DIAGNOSTIC STUDIES	
72040	CERVICAL 2-3 VIEWS	60
72050	CERVICAL COMP. 4 VIEWS	100
72052	CERVICAL 5-7 VIEWS	140
72070	THORACIC 2 VIEWS	60
72020	THORACIC SPINE 1 VIEW	60
72100	LUMBAR LIMITED, 2 VIEW	60
72020	LUMBAR SPINE, 1 VIEW	60
72020	L-5 SPOT VIEW	60
72114	LUMB. COMP. 2/BENDING	100
72110	LUMBAR W/OBL. 4 VIEWS	80
72170	PELVIS 1 view (AP)	40
73030	SHOULDER 3 VIEWS	80
76140	WRITTEN X-RAY REPORT	varies
	EXTREMITY VIEWS	
	Elbow	80
	Forearm	80
	Wrist	80
	Hip 2 views	100
	Hip 1 view	60
	Knee	80
	Ankle	80
	Foot	80

CPT CODE	DESCRIPTION	CHARGE
	MISCELLANEOUS	
99080	NARRATIVE	150
	DEPOSITION 1st HR. DUE PRIOR TO	400
	DEPOSITION EA. ADDL. ¼HOUR	150
	PROCEDURE	
98940	SPINAL 1-2 REGIONS	65
98941	SPINAL 3-4 REGIONS	70
98943	EXTRASPINAL, 1+REGION	30
	THERAPY	
97035	ULTRASOUND	22
97014	UNATTENDED ELEC. STIM	23
97010	HOT OR COLD PACKS	17
97110	THERAPEUTICS EXERCISES	45
97112	NEUROMUSCULAR RE-ED	45
97012	TRACTION/MECHANICAL	32
97140	MANUAL THERAPY TECHNIQ.	54
97530	THERAPEUTIC ACTIVITIES	45
	ORTHOPEDIC SUPPORTS	
99070	LUMBAR PILLOW	48
E0230	COLD PACK SMALL	12
E0230	COLD PACK HALF SIZE	22
E0230	COLD PACK FULL SIZE	30
E0230	COLD PACK CERVICAL	30
E0234	LAVA PACK	38
E0943	WATER CERVICAL PILLOW	62
E0943	CERV. SUPPORT PILLOW	40
E0943	SOFT CERV. SUPPORT PILLOW	38
L0515	LUMBOSACRAL SUPPORT	48
L3332	HEEL LIFT	5
L3700	ELBOW WRAP (TENNIS EL.BR.)	10
L3908	WRIST SUPPORT	25

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 establislted medical records and future records as created hv Mt. Lookout Cltiropractic 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 Iniury 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 twelve 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.

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 $110-$125. 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.

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, supplements, 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. ***If your account should become delinquent, the responsible party is aware that the account information will be turned over to collections and he/she will be responsible for the agency's collection fees as well as the outstanding balance.***

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 you are unable to keep your appointment we ask that you provide a:

- Chiropractic- 4 hours notice
- Physical Therapy- 24 hour notice or a $35 missed appointment fee may apply

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.

ADMINISTRATIVE FEE With the increased cost of providing healthcare services, we are implementing a $2 admin fee per date of service, per provider to continue to offer our excellent & high standard of care.

Patient Initials_____**CA Initials**_____

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

_____

Signature (Patient, Parent, or Legal Guardian)

_____

Print Name (Patient, Parent, or Legal Guardian)

_____

MLC Staff Witness

_____

Date

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

Mt. Lookout Chiropractic
& Sports Injury Center

455 DELTA AVE., SUITE 1
CINCINNATI, OH 45226
(513) 321-8484

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)*