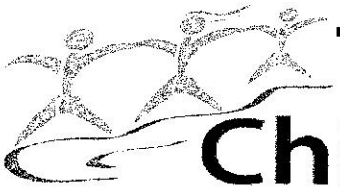


# Tuckahoe Chiropractic

32201 Queen Anne Hwy. Queen Anne, MD 21657
Phone 410-364-9222 Fax 410-364-9310 Email tuckchiro@live.com

**Dear _____,**

**Your new patient appointment has been scheduled for :**

*Date:_____at _____am/pm*

**Please arrive 15 minutes prior to your appointment time. Bring the following with you:**

*X-rays and/or MRI's (Disk & report) of the problem area if you have them.
*Insurance Card(s) &Co-Pay
*Driver's License or Photo ID
*New Patient Paperwork completed.
* Please wear separate tops& bottoms, as you will be disrobed/gowned from the waist up.

** Medicare, Priority Partners & United Healthcare DOES NOT pay for Xrays done in our office.**

**You will be responsible for payment if you have X-rays done in our office. ** Contact your PCP and have them order X-rays PRIOR to your appointment. Call our office if you have any questions regarding this.

Complete the paperwork and bring it with you to your appointment. If you don't have paperwork or it is not complete before you arrive or you are late, we will have to re-schedule your appointment. An appointment reminder/confirmation text or call will be sent to you the day before.

We dedicate a <u>minimum</u> of one (1) hour to each new patient appointment. Please extend us the courtesy of 24 hr. notice if you are unable to keep your appointment.

We look forward to meeting you. If you have any questions please feel free to contact me.

Thank you,

Brandi Arnold- Office Manager

# NEW PATIENT INFORMATION

Patient: _____ Date: _____

## Your Personal Information

Name: _____ Spouse: _____

Address: _____ City: _____ State: ___ Zip: _____

Home Phone: _____ Date of Birth: _____ SS#: _____ - ___ - _____

Age: _____ Gender: ☐ M ☐ F Marital Status: ☐ M ☐ S ☐ W ☐ D

Employer: _____ Work Phone: _____

Type of Work Performed: _____

In Case Of Emergency Notify: _____ Phone #: _____

Family Physician: _____ E-mail Address _____

Who Should We Thank For Telling You About Our Office? _____

## Your Current Health Concern

Primary Reason For Today's Visit: _____

Check The Severity Of Your Complaint: (Mild) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ (Severe)

When Did This Begin? _____ Experienced Previously? ☐ Yes ☐ Never

Is This Condition: ☐ Job Related ☐ Auto Accident ☐ Fall or Injury ☐ Other: _____

Other Doctors Seen For This Problem: _____

Other Doctor's Opinions or Diagnosis: _____

Other Or Secondary Health Concerns: _____

Drugs Or Medications Now Taking: ☐ Pain Killers / Muscle Relaxants ☐ Tranquilizers

☐ Blood Pressure Medicine ☐ Antibiotics

☐ Other: _____

## Your Past Health History

Previous Surgeries: ☐ Eyes / Ears / Nose / Throat ☐ Head/Neck ☐ Back /Spine

☐ Chest / Heart / Lungs ☐ Abdominal ☐ Other: _____

Previous Fractures Or Broken Bones: ☐ Yes ☐ No Describe: _____

Previous Falls Or Accidents: ☐ Yes ☐ No Describe: _____

Previous Hospitalization: ☐ Yes ☐ No Describe: _____

Previous Chiropractic Care: ☐ Yes ☐ No Describe: _____

Similar Problem In Family: ☐ Yes ☐ No Describe: _____

Similar Problems With Co-Workers: ☐ Yes ☐ No Describe: _____

Do You Workout Or Exercise? ☐ Yes ☐ No Describe: _____

TUCKAHOE CHIROPRACTIC 32201 QUEEN ANNE HWY, QUEEN ANNE, MD 21657 410-364-9222

*PLEASE COMPLETE OTHER SIDE*

# NEW PATIENT INFORMATION

## Check Any Of The Following That May Apply To You

**Health Issues:**

| | | | |
|---|---|---|---|
| ☐ Scoliosis | ☐ Arthritis | ☐ Infections | ☐ Sleeplessness |
| ☐ Lyme's Disease | ☐ AIDS or ARC | ☐ Heart | ☐ Chronic Fatigue |
| ☐ Diabetes | ☐ Frequent Illnesses | ☐ Allergies | ☐ Genetic Disorders |
| ☐ High Stress | ☐ Poor Diet | ☐ Epilepsy | ☐ Kidney Disorders |
| ☐ Under Weight | ☐ Lungs | ☐ Cancer | ☐ Polio |
| ☐ Endocrine | ☐ Over Weight | ☐ Other_____ | |

**If Female**, is there any possibility that you are pregnant? ☐Yes ☐ No

**Intake Or Use:**

| | | | |
|---|---|---|---|
| ☐ Alcohol | ☐ Tobacco | ☐ Pain Relievers | ☐ Caffeine |
| ☐ Sleeping Pills | ☐ Birth Control Pills | | ☐Other:_____ |

## Check Any Problems That You May Have Had Within The Last Six Months

**Muscles-Skeleton**

- ☐ Low Back Pain
- ☐ Middle Back
- ☐ Neck
- ☐ Hips / Legs
- ☐ Joint Pain
- ☐ Shoulders/Arms

**Circulation-Breathing**

- ☐ Chest Pain
- ☐ Lungs/Breathing
- ☐ Blood Pressure
- ☐ Heart Rate
- ☐ Poor Circulation
- ☐ Coughing or Wheezing

**Eye-Ear-Nose-Throat**

- ☐ Eyes / Vision
- ☐ Dental / TMJ
- ☐ Throat / Voice
- ☐ Ears / Hearing
- ☐ Sinus Pain / Drainage

**Nerve System**

- ☐ Headaches
- ☐ Nervousness
- ☐ Numbness
- ☐ Weak Muscles
- ☐ Dizziness
- ☐ Forgetfulnes
- ☐ Depression
- ☐ Fainting
- ☐ Seizures
- ☐ Cold Hands / Feet
- ☐ Stress Reactions
- ☐ Shaking / Tremors

**Digestion-Elimination**

- ☐ Poor Appetite
- ☐ Excessive Thirst
- ☐ Nausea
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Weight Loss / Gain
- ☐ Heartburn
- ☐ Change In Stools

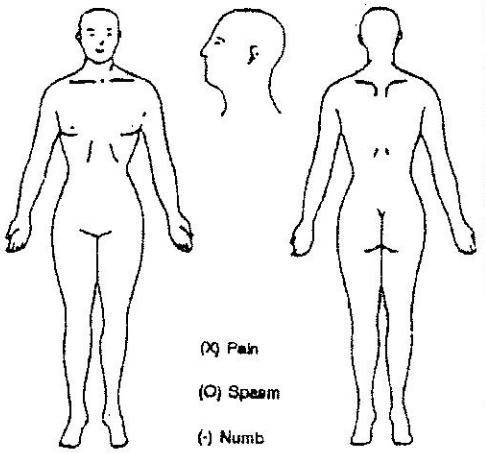
**Urinary-Genitals**

- ☐ Pain With Urination
- ☐ Infrequent Urination
- ☐ Frequent Urination
- ☐ Weak Stream
- ☐ Bladder Control
- ☐ Genitals

**Female Only**

- ☐ Menstrual Problems
- ☐ Back Pain w/ Period
- ☐ Breast Lumps/Pain
- ☐ Breast Implants

## Please Mark Area Of Concern & Sign




*I understand that my care in this office involves the making of judgements that are based upon the facts known by the doctor. Therfore, the above information is true and complete to the best of my knowledge*

_____

*Patient's Signature:*

TUCKAHOE CHIROPRACTIC 32201 QUEEN ANNE HWY, QUEEN ANNE, MD 21657 410-364-9222

# Back Index

Form BI100

rev 3/27/2003

Patient Name _____ Date _____

*This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

## Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

## Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

## Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

## Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

## Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

## Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

## Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

## Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

## Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

## Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

*Back Index Score* _____

# Neck Index

Form N1-100

rev 3/27/2003

*Patient Name* _____ *Date* _____

*This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

## Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

## Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

## Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

## Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

## Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

## Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

## Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

## Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

## Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

## Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

~~Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100~~

*Neck Index Score*

# The Keele STarT Back Screening Tool

Patient name: _____ Date: _____

Thinking about the last 2 weeks tick your response to the following questions:

| | | Disagree 0 | Agree 1 |
|---|---|---|---|
| 1 | My back pain has **spread down my leg(s)** at some time in the last 2 weeks | ☐ | ☐ |
| 2 | I have had pain in the **shoulder** or **neck** at some time in the last 2 weeks | ☐ | ☐ |
| 3 | I have only **walked short distances** because of my back pain | ☐ | ☐ |
| 4 | In the last 2 weeks, I have **dressed more slowly** than usual because of back pain | ☐ | ☐ |
| 5 | It's not really safe for a person with a condition like mine to be physically active | ☐ | ☐ |
| 6 | **Worrying thoughts** have been going through my mind a lot of the time | ☐ | ☐ |
| 7 | I feel that **my back pain is terrible** and it's **never going to get any better** | ☐ | ☐ |
| 8 | In general I have **not enjoyed** all the things I used to enjoy | ☐ | ☐ |

9. Overall, how **bothersome** has your back pain been in the **last 2 weeks**?

| Not at all | Slightly | Moderately | Very much | Extremely |
|---|---|---|---|---|
| ☐ 0 | ☐ 0 | ☐ 0 | ☐ 1 | ☐ 1 |

**Total score (all 9):** _____ **Sub Score (Q5-9):** _____


Funded by Arthritis Research UK

Tuckahoe Chiropractic

32201 Queen Anne Hwy.
Queen Anne, MD 21657
Phone: (410)634-9222
Fax: (410)634-9310
Collin D. Johnson, DC

## Notice to all Medicare Patients

Medicare does **NOT** pay for everything, even some care that you and/or your health care provider have good reason to think you need. Medicare will **NOT** pay for the following services **below** when ordered and/or delivery by a Doctor of Chiropractic. Most secondary insurances (to Medicare) do NOT cover these services. You will be responsible for payment AT YOUR VISIT.
* We will offer an estimation of charges, this is not a guarantee of the final cost, until treatment is discussed and rendered. *

| **Services:** | **Cost:** |
|---|---|
| 1. X-rays Done in OUR Office | $80-375 Depending on # of Views taken. |
| 2. Examinations- New Patient | $78-188 |
| 3. Re-examination/Evaluations (Progressive or New Injury) | $78-188 |
| 4. Physical Therapy to include: Stretches/Stim/Traction, Manual Therapy, Ect. | $25 |
| 5. Maintenance Care (No Insurance Billed) Adjustments and (PT) Physical Therapy | $80/$20 |
| 6. Extremities Adjustment (Shoulder/arm down to Fingers & Hips/leg down to Toes) (Ribs, Jaw) Any NON-Spinal. | $64 |

Your Estimated* Cost at today's (New Patient/Re-Establish/Eval) appointment

will be: $ _____

Signing below, you are stating you have read the above statements and understand this notice. Should you agree that the services are needed and are therefore rendered, you will be responsible for payment at the time of service.

_____ _____

Signature Date

**A. Notifier: Corsica Family Chiropractic, LLC. (Tuckahoe Chiropractic)**

**B. Patient Name:** **C. Identification Number:**

# Advance Beneficiary Notice of Noncoverage (ABN)

**NOTE:** If Medicare doesn't pay for **D. 1** below, you may have to pay.
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D. 1** below.

| D. | E. Reason Medicare May Not Pay: | F. Estimated Cost |
|---|---|---|
| 1. Spinal Manipulation<br>2. Physical Therapy/Stimulator/Traction/ Or Therapeutic Exercises | 1. Medicare does **NOT** pay for Maintenance or Wellness care | 1. $80.00 |

**WHAT YOU NEED TO DO NOW**

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D. 1** listed above.
  **Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

**G. OPTIONS: Check only one box. We cannot choose a box for you.**

☐ **OPTION 1.** I want the **D. 1** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D. 1** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D. 1** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

**H. Additional Information:**

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

| I. Signature: | J. Date: |
|---|---|
| | |

**CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.**

Tuckahoe Chiropractic

## Office Policies

Due to the increased volume of patients and the priority that we show to each and every one of our patients, we put the following polices in place. Please read and initial that you acknowledge each policy.

1. Appointment cancellations: We require 24 hours notice to cancel an appointment. We understand life happens and things come up without notice, however, if you need to cancel or reschedule your appointment please call us as soon as possible. Three (3) cancellations WITHOUT APPROPRIATE NOTIFICATION in a 6 month timeframe will result in your release from care for non-compliance. (initials) _____

2. In the event that you have cancelled your appointment(s) 3 times in a 6 month timeframe without 24 hours notice, you will be charged a $65.00 cancellation fee. This fee will be due before or at your next treatment with Dr. Johnson. (initials) _____

3. If missing your appointments (NO CALL/NO SHOW) becomes a continuous concern, we will deem it necessary to release you from our care. (initials) _____

4. We currently schedule our routine/continuous care appointments in 15 minute slots. If you have a NEW injury or concern, Please inform the front desk staff BEFORE seeing the Doctor. This may require another appointment, in a longer time slot to address the new injury and CANNOT be treated without an Evaluation. (initials) _____

5. We will make every effort to verify and obtain your Health Insurance Benefits and information. Ultimately it is Your responsibility to know your coverage, policy benefits and limitation details. If there are any changes with your insurance policy(s), to include receiving new insurance cards, it is Your responsibility to inform us BEFORE or AT your next appointment. (initials) _____

6. You agree to notify our office of any changes in your address, contact information or insurance provider, BEFORE or AT your next appointment. (initials) _____

Signature _____ Date: _____

Name (Printed) _____

Thank you & We appreciate you!

# INFORMED PATIENT CONSENT

## AND THE DOCTOR-PATIENT RELATIONSHIP

| | |
|---|---|
| **Chiropractic Care** | It is the premise of Chiropractic that the human body possesses the inherent potential to maintain itself in a natural state of homeostasis. A state of normal homeostasis allows the body to establish normal function, express appropriate adaptation, and employ its recuperative, health sustaining powers. The relationship between the spine and the nervous system may affect the conduction of the nerve impulses over the nervous system affecting that inherent potential. Therefore, chiropractic care focuses primarily on the chiropractic adjustment for the purpose of establishing proper spinal alignment thus allowing normal nerve conduction throughout the body. The success of chiropractic care often depends on the environment, underlying causes and the physical and spinal conditions of each individual patient. |
| **Chiropractic Analysis** | The doctor will conduct a clinical analysis for the express purpose of determining the presence of the vertebral subluxation and the effects of the vertebral subluxation complex. If such is not detected, the patient will be informed and an attempt to refer the patient to an appropriate health care provider will be made. |
| **Clinical Results** | The purpose of chiropractic care is to promote health though the correction of the vertebral subluxation complex. Since there are so many variables, it is difficult to predict the time schedule, degree of response, or the efficacy of the chiropractic adjustment for any given patient. However, the doctor may make recommendations for clinical management based upon known circumstances and clinical experience.<br><br>Due to the complexities of nature, and the many variables (both known and unknown) that can affect a patient's response, no doctor can promise specific results. The Doctor of Chiropractic is licensed to provide a specialized unique, non-duplicating health service. The Chiropractor is licensed in a special area of practice and is available to work with other providers in your health care regimen. |
| **Medical Diagnosis** | Although Doctors of Chiropractic are experts in the analysis of the structural alignment of the human spine and its effects on the nervous system, they are not internal medical or surgical specialists. Therefore, every patient should be mindful of their own symptoms and should secure other opinions should they have any concerns as to the nature of any other symptoms or their total health picture. Your Doctor of Chiropractic may express an opinion as to whether or not further consultation is necessary, but the patient is responsible for the final decision and any subsequent action. |
| **Contra-indications To Chiropractic Care** | Where vertebral subluxations are detected, the chiropractic adjustment is usually beneficial and seldom causes any adverse reactions. In rare cases, undetected physical defects, deformities, or pathologies may render the patient susceptible to such injuries as vascular accidents, fractures and disc injury. The doctor, of course, will not perform any procedures if there is awareness that such care may be contra-indicated. It is the responsibility of the patient to make it known if they are aware that they are suffering from: pathological conditions, illnesses, injuries, or deformities which may be known to the patient but have not have otherwise come to the attention of this doctor. By signing below, the patient affirms that they have been open and truthful in disclosing their health history, and gives the doctor permission and authority to examine and care for them in accordance with recognized standards and acceptable chiropractic analytical and corrective procedures. |
| **Patient Consent For Care** | ***Please discuss any questions or problems with the doctor before signing this statement of understanding and consent for care.***<br>I have read and understand the foregoing. I hereby request and authorize the doctor to render chiropractic care to me:<br><br>_____ _____<br>*Signature of Patient, Parent, or Guardian* *Date* |

TUCKAHOE CHIROPRACTIC 32201 QUEEN ANNE HWY, QUEEN ANNE, MD 21657 410-364-9222

Tuckahoe Chiropractic

# Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violation of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

**I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.**

_____ _____

**Print Legal Name** **Sign Legal Name**

**Date:**_____

# *DIRECTIVE FOR DISBURSEMENT*

## *"ASSIGNMENT OF INSURANCE BENEFITS"*

By this instrument, I authorize, instruct, and order any insurance company obligated by contractual agreement to reimburse me for allowable professional or medical services to make direct payment to:

The provider shall directly credit this payment to my account, and I have agreed to pay (in a current manner) the balance of all charges for professional services over and above the insurance benefits.

☐ ☐ I also authorize the release of any HIPAA protected health information pertinent to my case to any insurance company, claims adjuster, or attorney involved in this case for the purpose of securing insurance benefits payable to the above named provider or myself.

Initialed _____

**THIS IS A DIRECT ASSIGNMENT OF ALL BENEFITS TO THIS HEALTHCARE PROVIDER.**

_____ _____

*Signature of Policy Holder* **Witness**

_____ _____

*Signature of Claimant* *Date*

**A PHOTO COPY OF THIS DOCUMENT SHALL BE AS VALID AS THE ORIGINAL**

# *FINANCIAL OPTIONS*

**Welcome to our practice! We are proud to provide three options for the handling of our patient's financial accounts. Please review the following choices and check the type of arrangement that best depicts the way you would like us to handle your account.**

**Thank-you!**

## ☐ Non-Insured / Cash Option

The following policy applies to those patients who do not have health insurance benefits or to those who prefer to pay for their services and handle their own insurance processing.

1. Our office does not routinely bill patients for their care. Payment is requested at time of service.
2. We accept cash, check, MasterCard, VISA, and Discover as payment for your care.
3. We will not deny care to anyone based on their inability to pay for our services.
4. If necessary, we will make arrangements with patients who request that such arrangements be made.
5. We will provide forms, information, and the guidance to enable patients to process their own insurance claims if they so desire.

## ☐ Approved Insurance Option

The following policy applies to those patients with appropriate health insurance coverage. (We do not accept assignment on personal injury nor secondary insurance benefits.)

1. We will accept written assignment on the estimated amount of insurance benefits available through your primary insurance carrier.
2. Our office will estimate the total cost of non-insurance covered care, and pro-rate your portion into weekly payments.
3. Only patients undergoing active care will be eligible to assign their insurance benefits to this office.
4. If you should discontinue care prior to being released by doctor, all outstanding balances will immediately become due and payable.

## ☐ Medicare Option

The following policy applies to those patients with Medicare insurance coverage. We are a Medicare approved, "non-participating" provider. (Please ask for details.) The following policies are federally mandated.

1. We cannot accept assignment on the Medicare benefits, however we will make financial arrangements if necessary.
2. We must file for benefits on your behalf, but Medicare reimbursement checks will be sent directly to you. To avoid delays in your reimbursement, do not send any claims to Medicare yourself.
3. Medicare requires chiropractic x-rays, but will not pay for them.

I understand & agree to the policy option noted above.

Signature:_____ Date:_____

Patient: _____

TUCKAHOE CHIROPRACTIC 32201 QUEEN ANNE HWY. QUEEN ANNE, MD 21657 410-364-9222