Below
CHIROPRACTIC & WELLNESS

Patient Registration

Date_____ Name (F)_____(M)_____(L)_____

Address_____

City_____ State_____ Zip Code_____

Home Phone_____ Wk_____

Cell _____ Do you want to receive appointment text reminders? Y/N

Birth Date (M/D/Y) _____ Sex: Male ____ Female ____

Marital Status – Single ___ Married ___ Divorced ___ Widowed ___

Social Security #_____ E-mail_____

Spouse's/Parents Name_____ _____

Employer_____Occupation_____

Emergency Contact/Nearest Relative_____ Phone_____

Reason for consulting our office_____

Is your present condition Accident/Work related? Y/N Are you interested in? Wellness/Relief care only

Have you been under Chiropractic Care before? Y/ N Whom did you see? _____

Were you referred to us? (We like to thank others for their referral)_____

Insured's Information

Patient relationship to insured Self Wife/Husband Child Other

Insured's Name (F)_____(M)_____(L)_____

Social Security #_____ Date of Birth_____ Sex: M or F Effective _____

Ins Co/Primary_____ Contract#_____ Group#_____

Ins Co/Secondary_____ Contract#_____ Group#_____

PATIENT RIGHTS

This office will strive to ensure that your rights as a patient of this office are preserved. You have a right to a dignified existence, self-determination and communication with and access to persons and services inside and outside this office. You have the right to be free of coercion, discrimination and reprisal from our office in exercising your rights.

This office strives to promote health and healing of patients in a manner and an environment that maintains or enhances each patient's dignity and respect, in full recognition of his or her individuality.

You have the right to be free from verbal, sexual, physical and mental abuse. This office will not knowingly employ any individual who has been found guilty by a court of law of such offenses.

Compliance Officer and/or Compliance Manager will promptly investigate any alleged abuse of a patient.

You have the right to receive services in this office with reasonable accommodation of individual needs and preferences, except when your health or safety or the health and safety of other persons would be endangered. You have the right to communicate in your own language and receive assistance, as we are able to provide.

You have the right to be informed about the services offered by this office and the charges for those services. You also have the right to be informed of any changes in the services offered by this office or in the charges for its services.

You have the right to be informed about the care, treatment options and any change that may affect your health and well being.

You have the right to discuss any problem you encounter in this office with the doctor.

You have the right to be fully informed of your condition in a language you can understand.
In the event of:
(1) a significant change in your physical, mental, or psychological status,
(2) a need to alter treatment significantly or,
(3) a decision to transfer or discharge you as a patient of this office,
problems will be promptly addressed and corrective action will be taken.

You have the right to be informed about any changes in your care and treatment that my affect your well being. Information contained in your medical records is confidential and will not be disclosed to unauthorized persons without your written consent or the written consent of your legal guardian, except as required or permitted by law or as set forth below.

In some instances this office may choose to release or receive, without any further authorization from you, all or any part of your medical records to or from any person or entity which has or may have a legal or contractual obligation to pay all or a portion of the cost of care provided to you, including, but not limited to, hospital or medical services companies, insurance companies, worker's compensation carriers, Medicare, Medicaid or your employer. If you require a copy of your records, this office may charge you a reasonable fee for such copies.

You have the right to personal privacy, including privacy in accommodations, chiropractic treatment, written and telephone conversations.

You have the right to expect quality chiropractic care at a reasonable cost and that diagnostic testing will only be ordered if the doctor truly feels it is necessary.

You have responsibilities as a patient. You are responsible for providing information about your health, including past illnesses, hospital stays, and use of medicine. You are responsible for asking questions when you do not understand information or instructions. If you believe you cannot follow through with your treatment, you are responsible for telling the doctor. You and any family members/friends with you are responsible for being considerate of the needs of other patients and staff. You are responsible for providing information regarding insurance and for working with office personnel to arrange payment when needed. Your health depends not just on your visits to our office but in the long term, on the decisions you make in your daily life. You are responsible for recognizing the effect of life-style on your personal health**.**

Signed _____ Date _____

BELOW CHIROPRACTIC CENTER
FINANCIAL STATEMENT

1. **PROOF OF INSURANCE:** Please bring your insurance card(s) with you to every appointment. It is YOUR responsibility to inform the staff of Below Chiropractic Center when the cause for treatment should be billed to another type of insurance, such as, auto insurance, liability insurance company or worker's compensation instead of your regular primary insurance company.
   Verification of your insurance benefits is a service provided to you at no charge. The information we receive about your benefits comes directly from your insurance carrier. This is not a guarantee of payment. If you have questions about your insurance benefits, please contact your insurance carrier directly.

2. **PAYMENT IS DUE AT TIME OF SERVICE:** We accept cash, personal checks, debit and credit cards. All deductibles, co-pays and non-covered services are due at time of service unless payment arrangements have been made in advance. I assign to Below Chiropractic Center all money to which I am entitled for chiropractic expense relative to the service rendered. I understand and agree that I am financially responsible to Below Chiropractic Center for charges not covered by my insurance company.

   If you have Medicare, YOU will be required to sign a waiver (Medicare non-covered form) prior to treatment as Medicare may deem the treatment "medically unnecessary" according to HCFA payment guidelines and you will then be responsible for payment. All Medicare patients will be required to pay their co-pay unless proof of a secondary policy is evident.

   If your co-pay is based on a percent (example 20% is patient responsibility) and you do not have a secondary insurance policy, please be prepared to pay your co-pay amount.

3. **FINANCIAL ASSISTANCE:** If you have no insurance, have maximized your benefits, have a high deductible or you are currently medically or financially indigent but not eligible for Public Assistance, please ask to speak with our Financial Advisor.

4. **BILLING, PAYMENTS AND OVER PAYMENTS:** There may be services that are not covered by your health benefits contract. You will be expected to pay for those services in full.
   If you have any questions about whether or not a particular service is covered by your health benefits contract, someone in our office will be happy to assist you. If an overpayment is made by you on the account, a refund will only be issued if there are no other outstanding debts on other accounts containing the same guarantor of financially responsible party. Patient balances unforeseen at time of service will be billed to the address you have provided for billing purposes. It is YOUR responsibility to inform us of any changes in address, phone or employment. All balances are due in full within 14 days of the billing date. If you cannot pay the balance in full within 14 days, please contact our office to see if you qualify for any special payment arrangement options.

5. **PAST DUE AND DELINQUENT ACCOUNTS: :** Failure to meet your financial obligations may result in reporting you to credit bureaus, filing for a judgment in small claims court or other collection action against you. All attorney fees, court costs and other expenses related to collecting your account will be added to your outstanding balance.

_____ _____

Patient or Responsible Party's Signature Date

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR FORM PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

I hereby instruct and direct the _____Insurance Company to pay by check made out and mailed directly to:

Below Chiropractic Center
207 4th Avenue SE
Cullman, Al. 35055

If my current policy prohibits direct payment to doctor, then I hereby instruct and direct the insurance company to make the check payable to me and mail it to:

Below Chiropractic Center
207 4th Avenue SE
Cullman, Al 35055

The professional or chiropractic expense benefits allowable and payable to me under my current insurance policy will be rendered as payment toward the total charges for professional services.

THIS IS A DIRECT ASSISNMENT TO MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, and balance such as deductible and co-payments of said professional service charges over and above this insurance payment.

I hereby authorize the release of any information pertinent to my case to any insurance company, adjuster, physician or attorney involved in this case and hereby release Below Chiropractic Center of any consequences thereof. A photocopy of this Assignment shall be considered as effective and valid as the original.

Dated this _____Day of_____20____.

_____ _____

Signature of policyholder

Signature of claimant, if other than policyholder

NOTICE OF PRIVACY PRACTICES

THIS PRACTICE IS COMMITTED TO MAINTAINING THE PRIVACY OF YOUR PROTECTED HEALTH INFORMANTION, (PHI), WHICH INCLUDES INFORMATION ABOUT YOUR HEALTH CONDITION AND THE CARE AND TREATMENT YOU RECEIVE FROM THE PRACTICE.

THE PRACTICE MAY USE AND /OR DISCLOSE YOUR PHI FOR THE PURPOSE OF:

(A) Treatment- in order to provide you with the health care you require, the practice will provide your PHI to those health care professionals directly involved in your care so we may understand your health condition and needs.
(B) Payment- In order to get paid for services provided to you, the Practice would provide your PHI to those billing services pursuant to their billing and payment requirements.
(C) Appointment Reminder-The Practice may contact you to provide appointment reminder or information about your treatment benefits and services by mail at the address given by you, or telephoning your home and leaving a message on your voice mail or with the individual answering the phone.
(D) Sign-In Log- The Practice maintains a sign-in log for individuals seeking care and treatment in office. The sign-in log is located in a position where staff can readily see who is seeking care, as well as the individual's seeking care in the office.

AUTHORIZATION

Uses and/or disclosures, other than those described above will be made only with your written Authorization.

YOUR RIGHTS

1. You may request to review a copy of the HIPPA COMPLAINCE MANUAL located in the Practice, which contains more detailed information regarding your privacy rights.

Acknowledgement of Receipt of Notice of Privacy Practices
&
Patient and Emergency Contact Form

**** I hereby acknowledge receipt of Below Chiropractic Center, Inc. Notice of Privacy Practices.**

****** Any Doctor, staff, employee, or representative of Below Chiropractic Center, Inc. has my permission to discuss my account and medical conditions which may include, but is not limited to, appointment times, test results, symptoms, treatments, diagnosis, medications, billing or insurance information, or any type of protected health information with myself or the person(s) listed below in order to facilitate and coordinate my care, treatment, and payment. I understand that signing this form is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to Below Chiropractic Center, Inc. or by completing a new form at any time. I also give permission for any of the above listed information to be left on a voice mail at any of my or the below approved phone numbers. I understand that information left with someone other than myself or via mechanical means, such as an answering machine, may be subject to redisclosure by the recipient and may no longer be protected by Federal and State Law.

****This form will be placed in the patient's chart and maintained for 5 years. ****

Please *PRINT* a list of persons we may speak with:

_____ _____ **(____)_____**
Name Relationship Phone Number

_____ _____ **(_____)_____**
Name Relationship Phone Number

Name of Patient: _____ DOB: _____

Patient Signature: _____ Date: _____

If personal representative, relationship to patient:_____

CONSENT TO TREAT

I do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used.

The practice of chiropractic includes many standard examination procedures. These include physical examination, orthopedic and neurological testing, palpation, specialized instrumentations, laboratory tests, radiological examinations, physical therapy and rehabilitative procedures. Additionally there is a procedure unique to the chiropractic profession – the chiropractic spinal adjustment. Adjustments may be performed on joints of the spine and extremities.

Although spinal adjustments are considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows: Soreness, dizziness, fractures/joint injury, stroke.

Along with the doctor's examination, I have completed a case history and have discussed my past history to minimize the risk of any complication from treatment and I freely assume these risks.

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm.

I am aware of reasonable alternatives to these procedures such as rest, home applications of therapy, prescription or over-the-counter medications, exercises, possible surgery, or nontreatment.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction prior to my signing this consent form. I have made my decision voluntarily and freely. Having this knowledge, I knowingly authorize Below Chiropractic Center to proceed with chiropractic care and treatment.

_____ _____

Signature of Patient Date

_____ _____

Signature of Witness Date

Below Chiropractic Center

207 4th Ave SE
Cullman, AL 35055
(256) 734- 6813

Disclosure of Fees

99203	New Patient Comprehensive Exam	$85.00
99213	Expanded Service/Re-Exam	$63.00
98941	Manipulation 3-4 regions	$48.00
98940	Manipulation 1-2 regions	$38.50
97140	Manual therapy	$30.00
97110	Therapeutic exercises	$32.00
72040	Cervical X-Rays	$65.00
72070	Thoracic X-Rays	$75.00
72100	Lumbar X-Rays	$85.00
97012	Traction (Decompression therapy)	$35.00
97014	E-Stim (Muscle Stimulation)	$30.00
97035	Ultrasound	$30.00
97110	Therapeutic Exercise/Procedure	$35.00

I have read the above codes and fees and understand the cost of my care at Below Chiropractic Center. I understand that I am responsible for payment of all deductibles and co-payments related to my care. I understand that if I have a balance for medical services not paid, I will make a minimum payment of $50.00 each month or 25% of the outstanding balance whichever is greater. If my balance is not paid in a timely and monthly fashion, I promise to pay any and all collection, court, and attorney fees in the collection of my account. I further understand that if my treatment is associated with a personal injury or accident claim, all medical bills will be paid at 100% of the above fee schedule regardless of the outcome of my case. I understand that if a check or debit is returned for insufficient funds, I will be charged a $35.00 service charge. I have read and fully understand the above financial terms and prices.

Signed _____ Dated _____