GOSS CHIROPRACTIC CLINICS

In _____

Out _____

Goss Chiropractic Mission Statement:

To improve the health potential of the people around us by providing excellent quality service and care utilizing education, love & chiropractic.

Date_____

Name_____ Married_____ Single_____
(last) (first) (middle)

Address_____ City_____ State_____ Zip_____

Email_____ Home Phone_____ Cell Phone_____

Would you like EMAIL or TEXT (circle) notification of your appointments? YES or NO (circle) Carrier _____

Date of Birth_____ Age_____ Number of Children_____
(month) (day) (year)

Name of Spouse_____ Health_____

Name of Children_____ Health_____

Occupation_____ Employed By_____ Business Phone_____

Primary Care Physician (PCP)_____ Phone #_____

Briefly Describe Complaint_____

Past Surgeries _____

Referred by_____/_____

Have you had chiropractic before?_____ Where?_____

What health insurance company do you have?_____ Do you have an HSA, HRÅ or FSA? If yes, please circle.

DO YOU HAVE ANY DIFFICULTY WITH THE FOLLOWING? IF YES, MARK "X")

( ) Allergies*
( ) Asthma
( ) Arthritis
( ) Depression
( ) Sinus Trouble
( ) Trouble Sleeping
( ) Breast Implants
( ) Fatigue
( ) Thyroid Trouble
( ) Snoring
( ) Cancer
( ) Post-Menopausal
( ) Irritability
( ) Bypass Surgery
( ) Vascular Disease
( ) Painful Joints
( ) Swollen Joints
( ) Kidney Trouble
( ) Strokes

( ) Headaches*
( ) Migraines
( ) Cluster Headaches
( ) Shooting Head Pain
( ) Throbbing Head Pain
( ) Light Bothers Eyes
( ) Neck Pain*
( ) Base of Neck Pain
( ) Jaw Pain
( ) Head Feels Heavy
( ) Clicking or Grinding in Neck
( ) Muscle Spasms in Neck
( ) Stiff Neck
( ) Shoulder Tightness
( ) Tingling in Fingers
( ) Numbness of Arm or Hand
( ) Pins and Needles in Arms or Back
( ) Cool Hands
( ) Ear Infections

( ) Ringing in Ears
( ) Loss of Balance
( ) Mid Back Pain*
( ) Upper Back Pain
( ) Pain in Shoulder Blades
( ) Knots in the Back Muscle
( ) Stiff Mid Back
( ) Chest Pain
( ) Heart Trouble
( ) Gall Bladder Trouble
( ) Heart Attack
( ) Lower Mid Back Pain
( ) Heart Problems
( ) Stomach Disorder
( ) Indigestion
( ) Ulcer
( ) Low Back Pain*

( ) Menstrual Cramps and Pain
( ) Menstrual irregularity
( ) Herniated Disc
( ) Bulging Disc
( ) Pinched Nerve
( ) Pain into Legs
( ) Cold Feet
( ) Pain into feet
( ) Hip Pain
( ) Sciatic Pain
( ) Constipation
( ) Trouble Bending
( ) Intestinal Gas
( ) Pain into Buttock
( ) Wrist Pain*
( ) Elbow Pain
( ) Shoulder Pain
( ) Knee Pain
( ) Ankle Pain

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No SHOW/ Cancellation Policy

MASSAGE THERAPY

There will be a **$30 charge** for all **"No Show"** massage therapy appointments as well as appointments that are not cancelled **within 24 hours** of their scheduled date/time.

The massage therapist travels on an "as needed" basis to provide this service to our clients by appointment only.

Please respect his time and set up costs.

SIGNATURE (Patients Name) Date

PRINT (Patients Name)

Witness Signature Date

Willliam F. Goss, D.C., DACS

Certified Diplomat Council on Applied Chiropractic Science

www.gosschiro.com

5600 Metropolitan Parkway

Sterling Height, MI 48310

TEL: 586-264-2100 • FAX: 586-264-1117

Notice of Privacy Practices for Protected Health Information

This notice describes how medical information about you may be used and disclosed, as well as how you can get access to this information. Please review it carefully.

We are required by law to maintain the privacy of your health. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information at any time. We must abide by the terms of this notice while it is in effect, but we reserve the right to change the terms of our privacy notices. If we make a change, it will apply to all of your health information in our files, and we will notify you in writing if/when you come in for treatment.

Uses and Disclosures:
Below are some examples of how we might use or disclose your health information either written or electronically.

1. We may have to disclose your health information to another health care provider, hospital, etc., if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
2. We may have to disclose your examination, treatment, and billing records to another party (i.e. your insurance company), if they are potentially responsible for the payment of your services.
3. We may need to use information in your file for quality control or administration purposes to run our practices.
4. We may use your name, address, phone number, and clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you (i.e. exam results, special promotions, referral information, etc.) 164.520(b)(1)(iii)(A). If you are not at home a message will either be left on your answering machine, left with a family member and/or mailed to your home.

You have the right to refuse to give us an authorization to contact you regarding your care at this office, or to limit uses and disclosure of your health information. If you do not give us an authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care (including billing you by mail or collection proceedings). You cannot refuse to receive monthly statements or billings, nor can you limit the access to your insurance company if they are responsible for payment. You may inspect or copy the information that we use to contact you regarding your care at any time.

Permitted Uses and Disclosures Without Your Consent or Authorization:
Under federal law, we are also permitted and required to use or disclose your health information without your consent or authorization in the following circumstances:

1. We are providing health care services to you based on the orders (referral) of another health care provider.
2. We provide health care services to you in an emergency and we are unable to obtain your consent after attempting to do so.
3. If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

Your Right to Limit Uses and/or Disclosures:
You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. Any restriction should be requested in writing. We are not required to honor these requests. However, if we agree with your restrictions, the restriction is binding on us.

Revoking Your Authorization:
You may revoke your authorization to us at any time in writing. There are two (2) circumstances under which we will not be able to honor your revocation request:

1. If we have already released your health information before we receive your request to revoke your authorization. 164.508(b)(5)(I)
2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Confidential Communication:
We will attempt to accommodate any reasonable written request regarding how/where (i.e. mailing address or contact number) you would like to receive information about your health or the services that we provide.

Amending Your Health Information:
You have the right to request that we amend your health information for seven (7) years from the date that the record was created or as long as the information remains in our files. We require a written request to amend your records that includes a valid reason to support the change. We have the right to refuse your request.

Inspecting/Coping Your Health Information:
You have the right to inspect the health information contained in your files while in our office and/or have a copy made for you. The health information is available up to seven (7) years from the date that the record was created or as long as the information remains in our files. Your request must be in writing to inspect the records and/or have them copied. An appointment will be set up within thirty (30) days of your written request for you to inspect your records in our office. Requested copies of your records will be available within six (6) business days of the written request and **there will be a charge based on the amount of pages copied. Copies can be made of your x-rays for a charge of $6.00 for each disc.** The original film is the property of this office because we are required by law to keep it in out records. Original films can only be released on referral to another physician.

Re-Disclosure:
We cannot control the actions of others whom we have released your information for treatment. Information that we disclose may be subject to re-disclose by these individuals by these individuals/facilities and may no longer be protected by the federal privacy rules.

Accounting of Disclosures of Your Records:
You have the right to request an accounting of any disclosures (not listed below) made of your health information for six (6) years prior to the date of your request. The request must be in writing. The accounting will exclude the following disclosers:

1. Those required for your treatment, to obtain payment for services, to run our practice, and/or made to you.
2. Those necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.
3. Those requested for national security, intelligence purposes, or law enforcement officers.
4. Those that were made prior to the effective date of the HIPAA privacy law (April 14, 2003).

Complaints:
You may complain to us or to the Secretary for Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. Written correspondence should be addressed to:

Goss Chiropractic Clinics
Attn: HIPAA Compliance Officer
5600 Metropolitan Parkway
Sterling Heights, MI 48310

Secretary for Health & Human Services
200 Independence Ave. S.W.
Room 509F, HHH Building
Washington, D.C. 20201

This notice is effective as of _____. This notice will expire six (6) years after the date upon which the record was created. By signing below, I acknowledge that I understand and agree to the information stated above. I also acknowledge that I was given the opportunity to read all the information and ask questions.

Signature: _____ Date: _____
□ Adult Patient □ Parent or legal guardian □ Spouse

Printed Name: _____ Relationship to Patient: _____

GOSS CHIROPRACTIC CLINICS

Authorization & Assignment

I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account by receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will be immediately due and payable. Failure to pay amount due will put your account in default which will result in collection fees of 50%. In consideration of your undertaking me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment of any sum from my attorney to you, I now or hereafter owe you out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to you or I based in whole or in part upon the charges made for your services. If my current policy prohibits direct payment to Goss Chiropractic Clinics, then I hereby instruct the insurance company to make the check out to me as patient and mail it to me as follows:
   Sterling Heights: c/o Goss Chiropractic 5600 Metropolitan Parkway Sterling Heights, MI 48310
3. In the event any insurance company, obligated by contractual agreement to make payment to me or to you for the charges made for your services, refuses to make such payment upon demanding by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. I authorize the doctor to make complaints on my behalf to the insurance commissioner for any reason.
4. This authorization and assignment shall be valid and effective for all charges and fees hereafter incurred unless retracted and revoked by me in writing.
5. I understand that on all dates of service that I have presented myself in this office that I have desired treatment for my condition. I understand that my insurance company may rule these treatments to be not "medically necessary" in their opinion and if this happens, I am still responsible for payment.
6. By signing this document, I agree, in order for Goss Chiropractic Clinic to service my account or to collect any amounts I may owe, Goss Chiropractic Clinic and its third party billing and/or debt collection service providers may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which may result in charges to me. Additionally, I authorize contact via text messages or e-mails, using any e-mail address I provide. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, if applicable

Signature _____ Date _____

Witness (Office Use) _____ Date _____