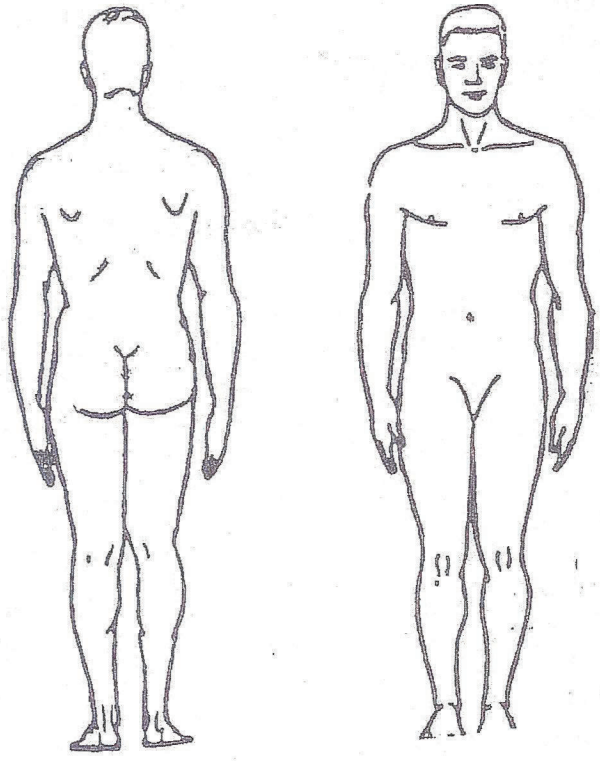
INFORMATION/APPLICATION FOR CARE

The following information is needed in order to best serve you. Please complete all questions. If you need help, feel free to ask the receptionist. PLEASE PRINT!

Today's Date _____
Patient Name _____ Phone _____ Work/Cell _____
Address _____ City_____ State_____ Zip_____
Email address _____
Age____ Date of Birth_____ Social Security Number_____ Marital Status: S M W D
Employer_____ Occupation_____ Years on job_____
Insurance Company_____
Name of Insured_____ Insured SS#_____ Insured DOB_____
Relationship to Insured: Self Spouse Child Other_____

COMPLETE THESE DIAGRAMS



Fill in the symptom chart to the left. Indicate location and degree of pain with the following:

DULL PAIN	X
SHARP PAIN	O
THROBBING PAIN	*
BURNING	^
PINS & NEEDLES	+
NUMBNESS	!
MUSCLE WEAKNESS	.
MUSCLE SPASMS	=
DECREASED MOTION	/
MUSCLE TIGHTNESS	#

MAJOR COMPLAINTS

Please list any conditions you are experiencing or currently being treated for: _____
_____
_____

Referred to our office by_____

BYU-I STUDENTS

Home address_____
City_____ State_____ Zip_____
Home Phone_____ Parent Name_____

Please notify the receptionist if your primary insurance is Medicaid or Medicare

VERTEBAL LISTING

CERVICAL

OCCIPUT_____

ATLAS_____alsp_____asrp

2____pls____prs____other

3____pls____prs____other

4____pls____prs____other

5____pls____prs____other

6____pls____prs____other

7____pls____prs____other

THORACIC

1___pls____prs____ant ____other

2___pls____prs____ant ____other

3___pls____prs____ant ____other

4___pls____prs____ant ____other

5___pls____prs____ant ____other

6___pls____prs____ant ____other

7___pls____prs____ant ____other

8___pls____prs____ant ____other

9___pls____prs____ant ____other

10___pls____prs____ant ____other

11___pls____prs____ant ____other

12___pls____prs____ant ____other

LUMBAR

1____pls____prs____#2B/L__ #2B/R

2____pls____prs____#2B/L__ #2B/R

3____pls____prs____#2B/L__ #2B/R

4____pls____prs____#2B/L__ #2B/R

5____pls____prs____#2B/L__ #2B/R

SACRUM

___base/P___base/A___ai/L___ai/R

COCCYX

___pls____prs_____other

KNEE/ LEG PULL

_____L_____R

PRONE NECK/RIB

_____L_____R

NUTRITIONAL SUPPORT

[DATE]_____

RIBS

Costo Vertebral

L 1 2 3 4 5 6 7 8 9 10 11 12

R 1 2 3 4 5 6 7 8 9 10 11 12

Costo Sternal

L 1 2 3 4 5 6 7 8 9 10 11 12

R 1 2 3 4 5 6 7 8

UPPER EXTREMITY

S/C Joint_____

Scapula_____

Humerous Ant/Inf _____

Humerous post_____

Ulna Post Med_____

Radius Post Lat_____

Wrist/Hand_____

Carpal Ant_____

Carpal post_____

Metacarpal_____

Phalangies_____

LOWER EXTREMITY

Hip/knee_____

Femur_____

Patella_____

Tibia Ant_____

Tibia Lat _____

Tibia Med_____

Tibia post _____

Fibula Ant_____

Fibula Post_____

Ankle/foot_____

Talus_____

Calcaneous_____

Navicular Ant_____

Nacicular Med_____

Cuboid Asup_____

Cuboid Ant/Lat_____

Cuboid Asup_____

Phalangies_____

PIRIRMS SYND

L_____

R_____

SINUS TREATMNT

L _____

R_____

CER-L_____

R_____

THOR-L_____

R_____

LUM-L_____

R_____

PERCUSS

OCC-top_____

EOP_____

Sub_____

SHLD-top_____

ant-L_____

R_____

lat-L_____

R_____

NOTES

OFFICE USE ONLY

AUTHORIZATION, ASSIGNMENT & RELEASE FORM

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorization 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 to you of any sum I now or hereafter owe you, by my attorney out of the proceeds of any settlement of my case, and/or by any insurance company, obligated to make payment to me or you based in whole or in part upon the charges made for your service.

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 demand by you. I herby assign and transfer to you the cause of action that exists in my favor against any such company (the name(S) of which is believed to be correctly set forth under pertinent date) and authorize you to prosecute and action in my name as your see fit and further authorize you to compromise, settle or otherwise receive and claim as you see fit, However, it is understood that until a reasonable effort has been made to collect the sums due from insurance company or companies contractually obligated, you will refrain from collecting the amounts owed, directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what is due. I personally owe and agree to pay to you.

4. In addition to the above, I herby waive the statute of limitations on collection and/or recovery in the State of_____.

5. I further agree that this Authorization is irrevocable and ongoing until all monies owed are paid in full.

6. This Authorization of assignment will be in continual effort until revoked by both parties.

_____ _____

Date Patient signature

RECORDS RELEASE

To_____, I herby authorize you to release to _____ any information including the diagnosis and records of treatment or examination rendered to me or all care during the period from _____ to_____.

_____ _____

Date Patient/Insured signature

_____ _____

Date Staff Signature

RELEASE FROM CARE

I, _____ herby understand that Dr._____ is releasing me from care, for my accident dated _____, and that I have reached pre-accident or maximum medical improvement. I further understand that all expenses incurred from this accident are my responsibility or insurance company's and that all expenses incurred after the date below will be my personal responsibility. I will make financial arrangements for payment directly.

Patients Signature_____ date_____ Staff Signature_____

Is your condition related to an accident (either personal, work, or auto)? Yes/No

If no, please continue to bottom section of page.
If yes, please list DATE of injury and nature of accident: _____
Auto Work Personal Other

If work related accident:

Do you intend to charge your treatments to a Workman's Compensation claim? Yes/No

If yes, please list employer/company name, address, and phone:

_____

_____

_____

Has an initial report of injury been filed with your insurance company through your employer? Yes/No

If auto accident:

Do you intend to charge your treatments to a Personal Injury/Motor Vehicle Accident claim? Yes/No

If yes, please provide the insurance information for the company to be billed:
Company Name: _____
Name of Insured: _____
Claim number (if available): _____
Name and phone number of claims adjustor (if available):_____
_____

If personal accident:

Please describe the nature of the accident:

_____

_____

_____

_____

_____

I hereby certify that the information provided in this application for care is accurate and true to the best of my knowledge. I (We) agree to see that services rendered to the patient are paid in full as incurred. In addition, if for any reason I choose to terminate or suspend my treatment, any outstanding fees for professional services will immediately due and payable.

Patient Signature_____ Date _____
Parent/Guardian signature (if patient under 18) _____ Date_____

THE BACKSMITH

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your chiropractic physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the chiropractor's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to another chiropractor, M.D., physical therapist, etc. to whom you have been referred to ensure that the other chiropractor, M.D., physical therapist, etc. has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission. For example, we have contracted with Northwest Medical Management Service who do our billing and our collections.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your chiropractors practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of new employees, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to chiropractic school students or pre-students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your chiropractor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment and/or send you a newsletter.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military activity and National Security: Workers' Compensation: Personal Injury Insurance: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your chiropractic physician or the chiropractic physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of you protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not by disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your chiropractic physician is not required to agree to a restriction that you may request. If chiropractor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your chiropractic physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You the have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

PATIENT NAME

ARBITRATION AGREEMENT AND INFORMED CONSENT, PAGE 1 OF 2 - PLEASE SIGN BOTH SIDES

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, and procedural disputes will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: **Procedures and Applicable Law**: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: **General Provision**: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: **Revocation**: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: **Retroactive Effect**: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _____. Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE (Or Patient Representative) X (Date)

(Indicate relationship if signing for patient)

PLEASE SIGN REVERSE SIDE ALSO

NCC

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office of clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT SIGNATURE X (Date)
(Or Patient Representative) (Indicate relationship if signing for patient)

OFFICE SIGNATURE (Date)

PLEASE SIGN REVERSE SIDE ALSO

Office Financial Policy

CASH

1. All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff.
2. This office may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings.

INSURANCE

1. If you have insurance, we will gladly accept assignment with the following exceptions and regulations, provided we have prior certification from your insurance company.
2. We accept assignment for the initial treatment plan only. Any follow-ups visits will be payable when services are rendered. Once you have been discharged form active care, we will continue to file your insurance, but require full payment per visit.
3. We accept assignment as courtesy to you; you are responsible for your entire bill should your insurance company not pay any of the anticipated charges for any reason. We are not a mediator between you and your insurance company and will not enter any dispute with same as your contact between you and your insurance company.
4. Whenever you receive any worksheets from your insurance company or explanation of benefits, please bring this information into our office as soon as possible. We must have a copy of this to determine if proper payment has been made. If you should receive a check from your insurance company during our billing has been done, we will issue you an overpayment check; it will not come from your insurance company. All insurance payments, regardless of which company issuers a check first, are applied to your balance is due.
5. Any services not covered or coverage reductions by your insurance will be the patient's responsibility.
6. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster, or agent. Any denied or disputed claim will be treated as uncovered services and you will be the patient's regardless of which company issues a check first, are applied to your account as any balance is due.
7. If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, the bill is due and payable in full immediately regardless of any claims submitted.

ADVANCE PAYMENTS

1. A 10% discount on all services is given when payment is made in advance to a minimum number of visits. In the event you discontinue care any balance will be prorated and refunded at regular cash rates.
2. Any personal balance remaining after 60 days may be assessed a monthly finance charge. Any account sent to collections will be assesses all collections fees. A $15.00 finance charge will be assessed to all accounts over 60 day without prior arrangements.

I have read all and understand the Financial Office Policy and agree to abide by these terms.

Signiture_____DATE_____

Patient Contact Information Form

Spouse's Name: _____ Work Phone: _____

Nearest Relative not living with you: _____

Phone: _____

Nearest Friend not living with you: _____

Phone: _____

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Landlord: _____ Phone: _____

Whom may we contact in the case of an emergency? _____

Phone: _____

Who is responsible for this bill? _____

I will be paying today by Cash_____ Check: _____ Credit Card: _____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the above information.

_____ _____

Signature Date

_____ _____

Parent (if minor) Date