Chiropractic FIRST
Redefining Health

Patient Name: _____

Assignment of Insurance Benefits

I hereby authorize payment to be made directly to Dr Mark Davis, of all benefits which may be due and payable under insurance coverage for the above named patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to Dr Mark Davis.

Authorization to Release Medical Record Information

Chiropractic FIRST is hereby authorized to disclose all or any part of the medical records on the above named patient to such insurance companies, organizations, or agencies as may be responsible for payment of services rendered by Chiropractic FIRST. This authorization I give with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage for services rendered by said Chiropractor.

The undersigned certifies that he / she has read and understands each of the above paragraphs and is the patient or responsible party with the power to execute this document and accept these terms.

Signature of Patient or Responsible Party: _____

Chiropractic FIRST, S.C. Financial Policy

Thank you for choosing Chiropractic FIRST, S.C. It is our policy to provide quality chiropractic services with minimal financial stresses. We are members of the most preferred provider networks to keep your costs low. We will file all insurance claims for your convenience. We also provide affordable cash plans for those without insurance. If you are not on a pre-paid discounted care plan, you will receive a statement at least once a month detailing the activity on your account over the past month.

Insurance: Upon your first visit, we will copy your insurance information. We will contact your insurance provider and determine your benefit coverage, and detail that information for you on your second visit. Please note: Details of benefit coverage are not a guarantee of payment. Insurance companies will pay what they feel is medically necessary. We will work with your insurance company to process your claim. Your insurance policy is a contract between you and the insurance company. Any claim that is denied is the responsibility of the patient. Once your frequency is once a week or less most insurance companies consider this maintenance and do not cover, therefore we have affordable patient payment plans for a time of service discount.

Co-pays: If your insurance policy requires a patient co-payment, such payment will be due at the time of service unless previous arrangements have been made. (Most of our patients with multiple appointments per week, or multiple family members, prefer to pay on a payment plan.)

Pre-Pays: All accounts are audited upon the cessation of care or end of care plan. Any pre-payment for services not rendered will be refunded or applied to future care as directed by patient. Payments are applied to services rendered, not based on time. Any pre-payment savings given at the beginning of care for decreased bookkeeping costs are therefore not given if audit before the end of care plan is needed and bookkeeping cost arise because of this. This previous credit will be deducted from any refund amount.

Medicare: If you have Medicare, you will be billed upon receipt of a Medicare payment to our office. If you also have a supplement to Medicare, we will bill Medicare first, then your insurance supplement. You will receive a bill after we receive an EOB (explanation of benefits) from your supplement insurance company.

As with all medical procedures, payment of service does not guarantee or imply cure. Individual results are reliant on a multitude of internal and external factors which in no way can be guaranteed. Payment is expected irrespective of outcomes.

*All payments are due upon receipt.
** Balances over 30 days past due will be assessed an interest rate of 4%. If an account balance becomes greater than 90 days past due and if no other prior payment arrangements have been made, the account will be turned over to our collections department. You will be responsible for all collection agency fees above and beyond your past due balance.

Insurance companies usually process claims within 10 days to 6 weeks. For this reason, it may sometimes be a month or two before you receive a bill for services. We accept pre-payment for services. If you have any questions at any time, please schedule a financial consultation with our Office Manager.

I have read and understand the financial policy:

Signature_____ **Date**_____

TERMS OF ACCEPTANCE
CHIROPRACTIC INFORMED CONSENT

Patient Name: _____

When a patient seeks chiropractic health care and we agree to provide this care, it is essential for the patient and Chiropractic FIRST to be working toward the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method with which it will be obtained. This prevents any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses. This misalignment results in a lessening of the body's God-given, innate ability to express its maximum health potential.

We do not offer to diagnose or treat any diseases or condition other than vertebral subluxation; however, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's God-given, innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

Your orthopedist, family practitioner, or past chiropractor may have discussed with you various modalities of pain relief: drugs, surgery, physical therapy, manipulation, etc. We want to make you aware of how care works in this office and what is available today, thanks to progress in spinal health care.

Adults: Chiropractic treatment can be successful at any age. The longer the subluxation has been there and the more damage that has been done, the longer it will take to correct and stabilize, and the more often you will need adjustments in order to maintain a healthy spine and nervous system.

Kids: Children's spines are very fragile, and improper alignment as a child can lead to permanent spinal impairment as they grow. Children get quick and profound results for a number of conditions clearly related to subluxation; therefore, it is best to check children for subluxation and begin any necessary treatment as young as possible.

Duration of Care: While pain relief may take only a few visits, getting well takes time. Depending on the patient's age, subluxation severity and lifestyle, adjustment and rehabilitative schedules for correction can range from six months to two years. Following correction, the doctor will make a recommendation for retainer care and lifetime maintenance.

As a rule, informed and cooperative patients can achieve positive Chiropractic results. Thus, the following information is routinely supplied to all who consider Chiropractic treatment. While recognizing the benefits of a healthy nervous system, you should also be aware that, like all areas of the healing arts, response to treatment and results cannot be guaranteed.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Chiropractic FIRST will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Chiropractic FIRST and will be credited to my account upon receipt. However, I clearly understand and agree that all my services rendered me are charged directly to me and that I am personally responsible for payment.

Family check-up: Spinal conditions are often silent and can go unnoticed by family and doctors for years. While we do not ask anyone to get care against their will, we do ask that all families receive a spinal check-up to discover whether significant spinal health issues exist.

Corrective care: Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that goes beyond simple pain relief and into what it will take to actually correct or optimize the normal position of your spine and central nervous system.

Wellness care: Spinal neglect is so common. It has become an epidemic in our society—despite the fact that your spine and nervous system control all function and healing in your body. Getting back to maintenance is the ultimate goal of Chiropractic. The gold standard for health care is to ensure the reduction of subluxation in the spine and then to maintain this for a lifetime.

I, _____, have read and fully understand the above statements.
(Print name)
All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I, therefore, accept chiropractic care on this basis.

Signature: _____ Date: _____

Consent to evaluate and adjust a minor child: I, _____, being the parent or legal guardian of _____ , have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Signature of parent/legal guardian: _____ Date: _____

Pregnancy Release: This is to certify that to the best of my knowledge, I am not pregnant. The above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.
Date of last menstrual period: _____
Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICE (NPP):

- **Open adjusting rooms:** We keep a semi open environment in the office to create a sense of warmth, family, healing, and education. During adjustments, we do not go over private information; however, you will be in an open area where others may see you and/or overhear conversation. If there is a need to discuss something of a personal or private nature, you should request an appointment in one of our closed private exam rooms. A doctor or trained staff member will speak with you about your condition or other matters in the closed private exam room.

- **To Family and Close Friends Involved in Your Care:** Our office has an open, family-centered approach to wellness and we believe it is in all our patient's best interests to have the support and cooperation of their families. Therefore, our office strongly encourages that the spouse or significant other be present when the doctor goes over the patient's report and recommendations for treatment and wellness.

  In addition, we may disclose your PHI (Personal Health Information) to a family member or a close friend if those persons accompany you while you are receiving health care services; or if we determine that it is in your best interest so we can provide you with the best health care possible. We may also disclose your PHI to a family member or someone else who helps pay for your health care treatment.

- **Requesting Restrictions:** You have the right to request a restriction in how we use or disclose your PHI. However, we are not required to agree to your request. For instance, if you request that your spouse or significant other not be present when the doctor presents your report to you, we will not agree to such request.

- **Right to Inspect and Copy**. You have the right to inspect and copy PHI that may be used to make decisions about your care. Usually, PHI includes medical and billing records. To inspect and copy PHI, you must submit your request in writing on the form provided by our Practice. We will usually respond to your request within sixty (60) days. If you request a copy of your PHI, we will charge a fee of $25.00, for the costs of copying, mailing or other supplies associated with your request.

Signature_____Date_____

The Chiropractic Office of Your Choice: Chiropractic FIRST

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

In the course of your care as a patient at Chiropractic FIRST, we may use or disclose personal and health-related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records, as well as your billing records, may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health-related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide us with this authorization; it will not affect the care provided to you, or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy, or amend your health-related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible, following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint or have any questions about our privacy notice, please contact Chiropractic FIRST at 262-363-5021.

This notice is effective as of your first date of service. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. Your signature acknowledges that you have received a copy of this notice.

_____	_____	__/__/____
Name (printed)	Signature	Date

*If you are a minor, or if you are being represented by another party:

_____	_____	__/__/____
Representative (printed name)	Signature	Date