Confidential Patient Case History Form

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nickname:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_ Northern Address (if applicable):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_

Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B:\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_ Marital Status (Please, Circle): S M D W Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we have your permission to send you text messages regarding appointment reminders, promotions, and deals? (Please, Circle) Yes No

Emergency Contact Name & Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

…………………………………………………………………………………………………………………………….

Height:\_\_\_\_\_\_\_ Weight:\_\_\_\_\_\_\_\_ How often do you exercise?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? Yes\_\_\_\_ No\_\_\_\_ Family Medical History:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication Intake:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Condition(s) Currently Being Treated For:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List Surgical Operations and When:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Physical:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Most Recent Bone Density Test:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had Chiropractic Care? Yes\_\_\_\_ No\_\_\_\_ Home Treatments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had treatment for your current condition recently or in the past? (Please, Circle) Yes No

Past Diagnostic Tests: X-rays\_\_\_\_\_\_\_ MRI\_\_\_\_\_\_\_ CT Scan\_\_\_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Findings:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your major complaint(s)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How and when did this start?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Radiation of Pain? Leg\_\_\_\_\_ Knee\_\_\_\_\_ Foot\_\_\_\_\_ Shoulder\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Symptoms: Burning\_\_\_\_\_ Tingling\_\_\_\_\_ Numbness\_\_\_\_\_\_ Shooting\_\_\_\_\_ Dizziness/Vertigo\_\_\_\_\_\_

Pain worse when: Sitting\_\_\_ Standing\_\_\_ Rising from Chair\_\_\_ Lying Down\_\_\_ Walking\_\_\_ Other\_\_\_\_\_\_\_\_\_

Pain interfering with: Work\_\_\_ Sleep\_\_\_ Daily Routines\_\_\_ Exercise\_\_\_ Golfing\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pain better with: Sitting\_\_\_ Standing\_\_\_ Walking\_\_\_ Resting\_\_\_ Medication\_\_\_ Ice\_\_\_ Heat\_\_\_ Activity\_\_\_

Are you suffering from: Lower Back Pain\_\_\_\_\_ Neck Pain\_\_\_\_\_ Shoulder Pain\_\_\_\_\_ Wrist Pain\_\_\_\_\_

Elbow Pain\_\_\_\_ Foot Pain\_\_\_\_ Knee Pain\_\_\_\_ Hand Pain\_\_\_\_ Headaches\_\_\_\_ Asthma\_\_\_\_ Neuritis\_\_\_\_ Nervousness\_\_\_\_ Digestive Disorders\_\_\_\_ Sinus Trouble\_\_\_\_ Heart Condition\_\_\_\_ Diabetes\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Women Only: Do you have any reason to believe that you may be pregnant? (Please, Circle) Yes No

How were you referred to our office?

* Please, place a checkmark next to applicable answer.

☐ Youtube

☐ Pinterest

☐ Word of mouth

☐ Article or blog post

☐ Other (please, specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ☐ Google

 ☐ Website

 ☐ Facebook

 ☐ Instagram

 ☐ Twitter

**Payment Is Due At The Time Services Are Rendered**

Our practice is acutely aware of the escalating healthcare costs and we are doing everything feasible to help lower them through increased efficiency. Recent changes in health benefits have resulted in larger patient co-pays, deductibles and coinsurance. It is costly and inefficient to send patients a bill/statement or to call the Insurance Company to verify your coverage. Our staff is happy to assist you in determining if you are in or out of network and will try to assist you in estimating what portion of our fees is your responsibility; however, this will NOT be a guarantee of coverage, and or payment. Due to the high volume in our office we might ask you to please verify your chiropractic coverage.

**Because insurance companies commonly misquote benefits and deductible status**, we request that you assist us in helping to reduce billing costs by completing the credit/debit card authorization below. By signing the authorization, you can be assured that your credit card will be charged only for those fees that your insurance company has determined that you owe. We honor all contractual obligations with insurance companies with which we participate, so you will never be charged for any amounts in excess of those that are allowed. You will be contacted via phone to be informed of the amount that will be charged to your credit card. The amount charged to your credit card will equal the amount shown on your EOB (Explanation of Benefits). If account has balance due to office for **which I am legally responsible, including co-pays, deductibles, coinsurance, non-covered charges, supplements, supplies, or missed payment at the time of appointment** the credit card will be charged.

Please note at ALL visits there will be a fee collected; whether it be, deductible, co-pay or coinsurance for the services rendered at the time of service. If for some reason we have collected a larger amount than needed, your account will be credited accordingly

**Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Card Holder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Credit/Debit Card # \_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ CVV # \_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_**

**Expiration (MM/YY) \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ Address #\_\_\_\_\_\_\_\_\_\_\_\_ MC Visa Disc Amex**

I CLEARLY UNDERSTAND THE FINANCIAL AGREEMENT AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED TO MY INSURANCE AND OR DIRECTLY TO ME AND THAT I AM RESPONSIBLE FOR PAYMENT. I AUTHORIZE FFLHS TO CHARGE MY CC. **I hereby agree that if this office is required to institute a legal action to collect any past due balance upon my account, I shall be responsible for attorney’s fees and costs of suit incurred by this office for said legal action.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient Date

**Health Insurance Claim Form**

In order for Shemansky Chiropractic, P.A. dba “Gulfshore Chiropractic Clinics” to submit claims to the insurance company, we must have patients sign the statements below. If not signed, Gulfshore Chiropractic Clinics, will assume you will be a cash patient.

**Patient’s or authorized person’s signature**. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient Date

**Insured’s or authorized person’s signature**. I authorize payment of medical benefits to the undersigned physician or supplier or services described below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient Date

**Financial Policy Notice**

All insurance companies must follow the federal regulations of the Centers for Medicare & Medicaid Services. Please note that federal law supersedes state law. The Medicare and Medicaid definitions for treatment are as follows:

**Maintenance Therapy/Wellness Care/Supported Care:** “is not considered to be medically reasonable or necessary under the Medicare/Medicaid program, and is therefore, **NOT PAYABLE**. Maintenance therapy is defined as a treatment plan that seeks to prevent diseases, promote health, and prolong and enhance the quality of life; or therapy is performed to maintain or prevent deterioration of a chronic condition. **When further clinical improvements cannot reasonably be expected from continuous ongoing care and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered MAINTENANCE THERAPY and is, therefore, NOT medically necessary.”**

**Chronic Condition:** “a patient’s condition is considered chronic when it is not expected to significantly improve or be resolved with further treatment, (as is the case with an acute condition), but where the continued therapy can be expected to result in some function improvement. **Once the clinical status has remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulative treatments is considered maintenance therapy and is NOT COVERED**.” Although we can stabilize the condition to an extent, but residual pain may still remain.

**Acute Condition:** “a patient’s condition is considered acute when it is expected to significantly improve or be resolved with treatment.”

**Exacerbated or Aggravated:** “an increase in severity of a disease or any of the signs or symptoms. This is typically due to significant irritation or flare up of the patient’s complaints without a specific incident.” (This may be secondary to performing the activities of daily living. i.e. you woke up feeling this way, bent over to pick something up, stumbled walking down the street, which gives you the right to hurt and allows you the right to be re-evaluated and ordered additional treatment).

**New Patient:** “is one who has NOT received any professional services from a physician, another physician of the same specialty who belongs to the same group practice within the past 3 years.” (If you’ve been treated by Dr. Shemansky before but have not been treated by him within the last 3 years, the law requires Dr. Shemansky to evaluate you as a new patient again in order to go through any medical changes within that time period in which you were not being treated).

**Re-Evaluation:** Medicare/Medicaid and Private insurance companies **REQUIRE** us to re-evaluate you, order a treatment plan, and then discharge you from care (**a start & finish to treatment MUST BE established**). An existing patient will be re-examined when a new symptom/injury occurs, or the patient’s previous symptom(s) becomes exacerbated and/or aggravated so a treatment plan can be established showing the care you are going to receive is medically necessary to satisfy Medicare guidelines. 90 days is the maximum before a re-evaluation is due again.

In an effort to maintain compliance with various state & federal regulations, managed care and preferred provider agreements; as well as billing & coding guidelines, we have adopted the following financial policies:

Our clinic has established a single fee schedule that applies to all patients for each service provided. You may be entitled to a network or contractual discount under the following circumstances:

1. We are a participating provider in your health plan.
2. You are covered by a State of Federal Program with a mandated fee schedule.
3. Patients who meet state and/or federal poverty guidelines or other special circumstances outlined in our “Hardship Policy” may be offered a discount for a period of time as determined by the clinic. Verification will be required.

As part of our compliance plan, as of January 1, 2012, our office will be unable to extend any type of discounts other than those listed above.

Acknowledged By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Informed Consent to Chiropractic Treatment**

**Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, of (City, State)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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 manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used. Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for muscular-skeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

**Soreness**: I am aware that, like exercise, it is common to experience muscle soreness in the first few treatments.

**Dizziness**: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

**Fractures/Join Injury**: I further understand that in isolated cases underlying physical defects, deformities or pathologies, like weak bones from osteoporosis, may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.

**Stroke:** Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve and brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in ten million is about the same chance as a normal dose of Aspirin or Tylenol causing death.

**Physical Therapy Burns**: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor.

Tests have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

**Treatment Results**

* I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.
* I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.
* I agree to the performance of these procedures by my doctor and such other persons of the doctor’s choosing.

**Alternative Treatments Available**

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

**Medications:** Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

**Rest/Exercise:** It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

**Surgery:** Surgery may be necessary for joint instability or serious disk rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

**Non-treatment:** I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment-making future recovery and rehabilitation more difficult and lengthy.

**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.**

To attest to m consent to these procedures, I hereby affix my signature to this authorization for this treatment.

Signature of Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

1. I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize Gulfshore Chiropractic Clinics to use and/or disclose to your insurance (Please, print name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ following specific protected health information: progress notes, X-ray notes, and any other requested correspondence.

2. I understand that this authorization is valid until patients’ treatment is completed.

3. I understand that the purpose or use of the disclosure I am granting: Thank you cards, phone calls, statements, and anything else necessary for your care.

4. I acknowledge that this authorization is voluntary.

5. The following is/are other criteria or limitations that I make regarding this authorization:

6. I understand that the office will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

7. I understand that this authorization may be revoked by the authorizer, in writing, at any time in accordance with the attached authorization revocation procedure. I also understand the revocation of this authorization will not have an affect on disclosure occurring prior to the execution of the revocation.

8. I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and that this information will no longer be protected by federal privacy regulations.

9. I understand that I, my health care, and payment for my healthcare will not be affected if I do not sign this form.

10. I understand that I may see and copy the information described in this form, if I ask for it, and that I will get a copy of this form after I sign it.

11. This form was completely filled in before I signed it. I certify that all of my questions were answered to my satisfaction and that I understand this authorization form and all of its contents.

12. This authorization is valid on \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_, the date I have signed below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient Name (Printed) Signature of Patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Legal Guardian Relationship to Patient

Witness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Notice of Receipt of Privacy Notice**

Protecting the privacy of your Personal Health Information (“PHI”) is important to us. Our privacy notice details how information about you may be used and disclosed and how you can get access to that information.

**By selecting I authorize being contacted for practice reminders by:**

Mail \_\_\_\_\_\_\_; Email\_\_\_\_\_\_\_; at email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_;

Telephone numbers; including Text and or Voicemail at: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(put phone # if different from personal information section)

**THIS FORM WILL BE PLACED IN THE PATIENT’S CHART AND MAINTAINED FOR SIX YEARS.** List below the names and relationship of people to whom you authorize the Practice to release PHI.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing the lines below I authorize the doctor to personally discuss with me products that may benefit my health or condition. I acknowledge that I was offered a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient Name (Printed) Signature of Patient

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Legal Guardian Relationship to Patient

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date Signed Witness

**OFFICE POLICIES**

**Cash Patient:** (No insurance coverage) Payment is due at the time of service is rendered. Once you have become an established patient, other options such as payment plans, etc. may be discussed.

**Insurance Coverage**: In today’s insurance climate there are numerous and varied insurance coverage’s. It is necessary for us to have a ***copy of your insurance card*** prior to accepting your insurance benefits. We will call your insurance company to verify your coverage. ***You will be considered a cash patient until your benefits can be determined***. Co-payments must be paid at the time of service. Deductibles (if out of network) must be paid at the time of service until met. Many times coverage varies from what is printed on your insurance card. We will make every effort to determine your coverage prior to your treatment or examination and discuss such in detail.

* \*\*\*Your insurance policy is an ***agreement between you and your insurance company***. Your help in obtaining benefits is very important. In other words, you have more influence with your company than we do. Ultimately, services rendered to you are your responsibility, regardless of your insurance company.
* Referral from Primary Care Physician: Some HMO’s and PPO’s require a referral from your Primary Care Physician to receive chiropractic benefits. It is your responsibility to contact your Primary Care Physician and get such a referral if one is necessary. Dr. Chip Shemansky will gladly speak with your physician and help with this referral.

**Workers Compensation**: We do accept Workers Compensation cases. Communication with your employer is very important. Notify us immediately if you feel your case should be filed under Workers Compensation. **By Law**, your employer and our office are bound to certain time frames for filing claims under Workers Compensation.

**Personal Injury Cases:** We will accept Personal Injury cases. We must receive all insurance information prior to accepting your auto insurance as payment. We will call your insurance company and verify your coverage. We will discuss your coverage with you in detail and whenever possible prior to treatment or examination.

**Financial Policy**:

There are **many varied types of financial arrangements** that are available to our patients. These range from cash patients, payment plans, and partial insurance coverage to full insurance coverage. Workers Compensation, Auto Insurance, and Medicare are also some of the other options. It can be quite complicated at times. Regardless of the arrangements made, your participation and cooperation is necessary and very important. Please, make certain to read all of your office and financial policies and ask any questions you may have. We do not want to discontinue your treatment because of a problem. **Please, keep the lines of communication open**.

(IF COLLECTION PROCEDURES ARE NECESSARY A 30% FEE WILL BE ADDED)

**Missed Appointments:**

The outcome of your treatment program is based on a number of factors such as; severity of your condition, age, lifestyle, type of work, keeping scheduled appointments, and other aspects. **Keeping scheduled appointments** is one of the most important factors and is the one factor that is totally out of our control. We understand that situations arise that are unforeseen and cause you to reschedule an occasional appointment. ***If you need treatment and don’t receive it, your treatment results will suffer***. Please, notify us ASAP if you cannot keep a scheduled appointment. ***Second missed appointment without prior notification will result in a $50 no-show charge***. Our goal is to help you get well as quickly as possible. Your cooperation is a necessity.

**Cancelled Appointments:**

If you cancel your appointment the day of you will be charged a **$25 cancellation fee**, unless cancellation reason is justified. Our goal is to help you get well as quickly as possible. Your time is important as well as the time we set aside for your specific treatment. Last minute cancellations affect our office greatly as we have turned away other patients who require care. Please, be respectful of your time and ours. Your cooperation is a necessity.

**Estimated Treatment Time:**

It is impossible to predict the exact length of time your treatment will take. For the best outcome, be sure to follow all of our recommendations. Dr. Chip Shemansky will thoroughly explain your condition prior to starting treatment. He will give you his professional opinion on how long it will take to treat your condition and answer any questions you may have. Good communication is important to us. We want you to understand your condition and treatment.

**Referrals:**

Most of our “new patients” come to out office by word-of-mouth. Your referrals are welcomed, expected and are the “life blood” of this practice. Help us help others. Please, spread the word about chiropractic experiences and the service you received at this office. If you are happy with us, tell others and if you’re not, tell us. If there is some way we can serve you better, please let us know. One of our goals is to continue to improve our service.

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Please, print name) have read through and understand the Office Policies for Gulfshore Chiropractic Clinics. I also understand that I will ultimately be responsible for services rendered regardless of my insurance coverage, cancellation and/if any missed or cancelled appointment fees, as outlined above.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATIONS & RELEASES**

**Assignment of Benefits & ERISA** ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I irrevocably assign and convey directly to the above-named provider, as my designated authorized representative, all insurance benefits, if any, otherwise payable to me for services rendered by provider, regardless of its managed care network participation status. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named provider or their attorneys in order to claim such benefits.

I also assign and/or convey to the above-named provider, as my designated authorized representative, any legal or administrative claim or chosen action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning expenses incurred as a result of services received from the provider. This includes an assignment of ERISA breach of fiduciary duty claims. I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services provided by the above-named provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The above-named provider or their representative is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or actions against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider, as my assignee and my designated authorized representative, may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

This assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered as valid as original.

**I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.**

Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_