Welcome

Patient Information

Date _____

SS/HIC/Patient ID # _____

Patient Name _____ _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____
Name of Insurance Company(ies) and assign directly to

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Phone Numbers

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

Accident Information

Is condition due to an accident? ☐ Yes ☐ No

Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

_____

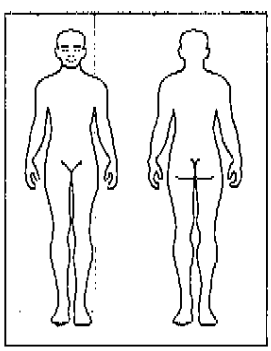
Patient Condition

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Health History

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Chicken Pox	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No	Other _____		
			Kidney Disease	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			

EXERCISE
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS
- ☐ Smoking — Packs/Day _____
- ☐ Alcohol — Drinks/Week _____
- ☐ Coffee/Caffeine Drinks — Cups/Day _____
- ☐ High Stress Level — Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications

Pharmacy Name _____

Pharmacy Phone (____) _____

Allergies

Vitamins/Herbs/Minerals

VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date_____

Patient Name _____

Date of Accident _____ Time of Accident_____ ☐ a.m. ☐ p.m.

Please describe the accident in your own words: _____

_____

_____

_____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian

How many people were in the accident vehicle?_____

ACCIDENT SITE

Road/Street Name_____

City/State _____

Nearest intersection with road/street_____

Driving conditions ☐ Dry ☐ Wet ☐ Icy ☐ Other _____

Which direction were you headed?_____

Speed you were traveling?_____

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No

If yes, explain_____

_____

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No If yes, explain _____

Was impact from :

☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other_____

At the time of impact were you:

☐ Looking straight ahead ☐ Looking to the right

☐ Looking to the left ☐ Looking down

☐ Looking up

Were both hands on the steering wheel? ☐ Yes ☐ No

If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No

If yes, which foot was on the brake? ☐ Right ☐ Left

Were you: ☐ Surprised by impact ☐ Braced for impact

VEHICLE

Make and model of vehicle you were in:

_____

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, what type? ☐ Lap ☐ Shoulder

Was vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

If yes, what was the position of the headrest?

☐ Low ☐ Midposition ☐ High

OTHER VEHICLE

(if applicable)

Make and model of other vehicle_____

Which direction was other vehicle headed?_____

Speed other vehicle was traveling_____

POLICE

Did the police come to the accident site? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No

If yes, to whom?_____

– OVER –

PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long?_____

Please describe how you felt immediately after the accident:

_____

_____

_____

TREATMENT

Did you go to the hospital? ☐ Yes ☐ No

When did you go? ☐ Immediately after accident ☐ Next day ☐ 2 days or more after the accident

How did you get to the hospital? ☐ Ambulance ☐ Private transportation

Name of hospital_____ Name of doctor_____

Diagnosis_____

_____

Treatment received_____

_____

X-rays taken_____

SYMPTOMS/INJURIES

Have you been able to work since this injury? ☐ Yes ☐ No How many work days have you missed?_____

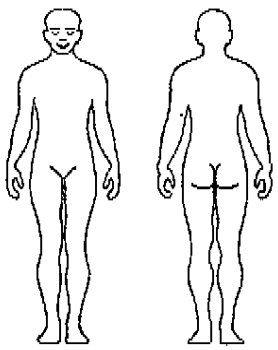
Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No

If you have had any of the following symptoms since your injury, please ☑ check:

☐ Arm/shoulder pain	☐ Feet/toe numbness	☐ Neck pain
☐ Back pain	☐ Hand/finger numbness	☐ Neck stiff
☐ Back stiffness	☐ Headaches	☐ Shortness of breath
☐ Chest pain	☐ Irritability	☐ Sleep difficulty
☐ Dizziness	☐ Jaw problems	☐ Stomach upset
☐ Ear buzzing	☐ Leg pain	☐ Tension
☐ Ear ringing	☐ Memory loss	☐ Vision blurred
☐ Fatigue	☐ Nausea	

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____

Type of pain:

☐ Sharp	☐ Dull	☐ Throbbing	☐ Numbness
☐ Aching	☐ Shooting	☐ Burning	☐ Tingling
☐ Cramps	☐ Stiffness	☐ Swelling	☐ Other_____

How often do you have this pain?_____

Is it constant or does it come and go?_____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

I certify that the above information is correct to the best of my knowledge.

Patient Signature_____ Date_____

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. 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.

SIGNED ____ DATE ____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. ____ 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Mfd. by Medical Arts Press
Call toll-free: 1-800-328-2179

#14710 - Medical Arts Press
Use with Envelope #14145 (gummed) or #14146 (self-seal)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Fold

Fold

Whole Health Chiropractic

HIPAA Acknowledgement

(Please print)

Name: _____ **Date of Birth:** _____

Mailing Address: _____

At which of the following phone number(s) do we have permission to contact you?

- ○ Home _____ May we leave a message for you at home? □ Yes □ No
- ○ Cell _____ May we leave a message for you on your cell? □ Yes □ No
- ○ Work _____ May we leave a message for you at work? □ Yes □ No
- ○ Other _____ May we leave a message for you at this number? □ Yes □ No

Other than you or your insurance company, whom may we speak to about your healthcare information?

- ○ Spouse Name/Telephone _____
- ○ Child Name/Telephone _____
- ○ Parent Name/Telephone _____
- ○ Caretaker Name/Telephone _____
- ○ Other Name/Telephone _____

Do you have any health information that you would like to be kept confidential from any of the people you have listed? □ Yes □ No
If so, please describe below:

_____

_____

I acknowledge that I have been given the opportunity to request restrictions on the use and/or disclosure of my protected heath information.

I acknowledge that I have been given the opportunity to request alternative means of the communication of my protected health information.

I acknowledge that I have read and signed a copy of the Privacy Notice for Whole Health Chiropractic.

_____ _____
Patient or Personal Representative Signature Date

_____
Relationship to Patient

Whole Health Chiropractic Notice of Privacy Practices

We understand that treatment information about you and your health is personal. We are committed to protecting information about you. This notice briefly describes how treatment information about you may be used and disclosed.

We are required by law to:

- Make sure that treatment information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to treatment information about you; and
- Follow the terms of the notice that is currently in effect.

We may use treatment information about you to provide you with treatment or services. We also may disclose information about you to people outside the clinic who may be involved in your care, such as family members or others we use to provide services that are part of your care.

We may use and disclose treatment information about you so that the treatment and services you receive at the clinic may be billed to and payment may be collected from you, your insurance company, or a third party.

If you are involved in a lawsuit or a dispute, we may disclose treatment information about you in response to a court or administrative order. We may also disclose treatment information to a subpoena, discovery request, or other lawful process by someone else involved in the dispute as required by federal, state or local law.

You have the right to inspect and copy treatment information that may be used to make decisions about your care, usually, this includes treatment billing records. We may charge a fee for the costs of copying, mailing or other supplies associated with your request.

You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of treatment information about you.

You have the right to request a restriction or limitation on the treatment information we use or disclose about you for treatments, payment, or health care operations. In your written request, you must tell us (1) what information you wanted limited; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example disclosure to your spouse.

You have the right to request that we communicate with you about your treatment matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

If you have any questions or concerns about your treatment in regard to our policies, would like to inspect a complete copy of this document, obtain copies of your treatment information, or restrict disclosure of your treatment information, please contact us at 972-530-2273.

_____

Print Name

_____ _____

Patient Signature Date

We reserve the right to change this notice without prior notification to you.

PATIENT FINANCIAL PROFILE
PERSONAL INJURY

OUR OFFICE POLICY REGARDING PERSONAL INJURY INSURANCE

Dr. Teresa Jones will be pleased to accept your personal injury insurance coverage as soon as you determine how you would like to file the claim. We will file the claim forms and assist in every way we can.

However, it must be understood that you are ultimately responsible for full payment of services rendered at Whole Health Chiropractic. We do not imply that insurance will cover all expenses.

Office policy regarding Personal Injury Protection (PIP):

☐ _____ I was injured in a motor vehicle accident and this claim is being submitted through my automobile insurance company for PIP coverage.

Insurance Company Information:

Name:_____ Claim No._____ Date Of Accident:_____

Address:_____

Claims Adjuster: _____ Telephone:_____Fax: _____

Office policy regarding Third Party Liability with Legal Counsel:

☐ _____ I was injured in a motor vehicle accident as a result of third party negligence and request that the doctor extend credit to me for services rendered until settlement of the third party claim with legal counsel has been obtained. I fully understand that my treatment will be on hold until a ***Letter of Protection*** is received by Whole Health Chiropractic from my attorney. I am aware that it is my responsibility for outstanding charges that remain for my treatment unless a payment arrangement has been obtained through legal representation.

Attorney Information:

Name: _____ Telephone: _____ Fax: _____

Address: _____

If you understand and agree with the statements that are checked above, initial the lines next to the checked boxes and sign the form below.

_____ _____

Patient Signature Date

Whole Health Chiropractic
Teresa Jones, D.C., C.Ad.
3930 Naaman School Rd. Ste. B
Garland, TX 75040

ASSIGNMENT OF BENEFITS

INSURANCE COMPANY_____

The undersigned patient and/or responsible party, in addition to continuing personal responsibility and in consideration of treatment rendered or to be rendered assigns to the facility or doctors named above the following rights, power and authority:

RELEASE OF INFORMATION

You are authorized to release information concerning my condition and treatment to my insurance company, attorney, or insurance adjuster, for purposes of processing my claim for benefits and payment of services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS

You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment and prosecute and receive penalties, interest, court costs, or other legally compensable amounts owned by an insurance company, in accordance with Article 21.55 of the Texas Insurance Code or other applicable insurance or state statute. I, as the patient and/or responsible party, further agree to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT

To any insurance company providing benefits of any kind to me/us for treatment rendered by the doctors/facility named above, you are hereby tendered demand to pay in full the bill for services rendered by the doctors/facility named above within 60 days following your receipt of such bill for services to the extent such bills are payable under the terms of my/our policy for benefits, less any amount which I/we personally owe which are not payable under the terms of the policy. This demand specifically conforms to Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court costs, and interest from judgments, upon violation.

THIRD PARTY LIABILITY

If my injuries are the results of negligence from a third party, then I instruct the liability carrier to issue a separate draft to pay in full all services rendered, payable directly to the doctors/facility named above.

STATUTE OF LIMITATIONS

I waive my rights to claim any Statute of Limitations regarding claims for services rendered or to be rendered by the doctors/facility named above, in addition to reasonable costs of collection, including attorney fees and court costs if incurred.

LIMITED POWER OF ATTORNEY

I hereby grant to the doctors/facility named above the power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment an health care rendered by doctors/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the doctors/facility named above.

TERMINATION OF CARE WAIVER

I hereby acknowledge and understand that if I do not keep appointments as recommended to me by the doctor at this chiropractic clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If, during the course of my care, my insurance company required me to take an examination from any other doctor, I will notify the doctors/facility immediately. I understand that failure to do so may jeopardize my case.

A photocopy of this instrument shall serve as original.

Signature of Patient and/or responsible parties:

Signature_____ Date_____

Staff Signature_____ Date_____

WHOLE HEALTH CHIROPRACTIC
FINANCIAL POLICY

Thank you for choosing Whole Health Chiropractic (WHC) for your chiropractic care. We are committed to providing you with quality health care. Our financial policy is as follows:

• Please note that you will need to present your insurance card and proof of identity (e.g. driver's license) at your first visit. You will be responsible for providing a change of address, telephone number and/or insurance information anytime a change occurs. We accept cash, major credit cards, and debit cards.

I. WHC has provider contracts with some insurance carriers with "in-network" status.

- Insurance contracts require us to collect your co-payment at the time of service.
- Our office will assist you in receiving proper reimbursement by filing your claim promptly.
  - ☐ After your insurance company processes the claim, (in about 30 days) you will receive an Explanation of Benefits (EOB) from your insurance, which will show the "***Patient Responsibility***"amount.
  - ☐ If there is a balance, we will provide you with a statement showing the amount due.
  - ☐ For large balances, you may contact our Billing Department to make payment arrangements using your credit/debit card.

- Individual coverage varies dramatically within our contracts and your coverage is an agreement between you and your health plan/health insurance company.
- It remains your responsibility to verify that the care you receive is covered by your health plan/health insurance.
- This office is not responsible for the expense of treatment not paid by your health plan/health insurance.
- With continuous changes in coverage, you should verify your benefits and understand all requirements of your health plan/health insurance by calling the customer service number on your health plan/health insurance card.

II. When WHC does not have a contract with your health plan/health insurance carrier, services are "Out of Network"

- This means that you may have no insurance benefits with our clinic.
- You will be responsible for the entire amount at the time services are rendered.
- As a courtesy, we can file a claim to your health plan. Should your plan pay, you will be refunded.
- Your signature on this Financial Policy will be your acknowledgement that you are aware that your Benefits will be paid as "out of network".

III. Motor Vehicle Accidents (MVA) & Third Party Liability

- WHC will file claims for services provided as the result of a motor vehicle accident or third party Liability injury; however, the patient will be responsible for the entire account.
- You will be required to complete a special Vehicle Accident Information form before you will be seen by the doctor.
- For Third Party cases, a prepayment of $85 will be required on the initial visit.

IV. Workers' Compensation

- Patients with *authorized* Workers' Compensation will not be subject to this Financial Policy.

V. No Insurance Coverage (self pay)

- The patient or guardian will be responsible for payment, which may include x-rays at the time of service. The Office Visit charge will be $85. There will be an additional charge for x-rays, tape, decompression and other services.

VI. Referrals

- If your health insurance requires a referral from your primary care provider (PCP) for your visit with our practice, the referral must be obtained by the patient and presented to us at the time of the visit. If you do not have the required referral from your PCP, the visit will be re-scheduled to allow time to contact your PCP and arrange for a referral.

I have read the financial policies of Whole Health Chiropractic and accept responsibility for payment of my account.

Patient Name_____ _____ Date of Birth: _____

Responsible Party Signature_____ _____ Date_____ _____