Office Financial Policy

Our Office is considered a private pay office, meaning we do NOT bill 3rd party insurance.

1. This office will make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed after your report of findings.
2. Please call at least 24 hours before your scheduled appointment if you need to reschedule. This allows for the change to be made and for the available time to be open for another patient.
3. If the patient discharges self from care, the balance is due in full for services that have been rendered. If payment arrangements are set up, it will be an auto-debit system.

Medicare/Insurance

4. If you have **Traditional Medicare**, as a courtesy to you, Claims will be submitted on your behalf so if Medicare chooses to reimburse you, they will directly.
5. Medicare policy, or a private insurance policy, we will give you all the necessary paperwork for you to submit your own claims to your insurance.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Central Clinic of Chiropractic, will provide the necessary information to assist me in making collection from the insurance company and any amount authorized to be paid directly to Central Clinic will be credited to my account. However, I clearly understand and agree that I am personally responsible for payment due for services rendered.

Signature: _____ Date:_____

Central Clinic of Chiropractic
11 E Calhoun St
Sumter, SC 29150
(803) 757-1700

Please fill out the application entirely and legibly. We need all information for insurance purposes.

Name: _____ **Nickname:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: _____ **Email:** _____

We will need to contact you both by phone & email. Please be sure to give us the best phone number to reach you

Date of Birth: _____ **Social Security:** _____

If you have Medicare, we need you to list your SSN above or provide us with the Medicare card

Spouse Name: _____ **Phone Number:** _____

Your Occupation: _____ **Retired:** Yes ☐ No ☐

REVIEW OF SYMPTOMS

Please check all that apply

- ☐ Foot Pain
- ☐ Hand Pain
- ☐ Low Back Pain
- ☐ Neck Pain
- ☐ Foot Numbness
- ☐ Hand Numbness
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Pacemaker/ Defibrillator
- ☐ Herniated Disc
- ☐ Bulging Disc
- ☐ Spinal Stenosis
- ☐ Degenerative Disc
- ☐ Vascular Problems
- ☐ Leg Pain
- ☐ Morton's Neuroma
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Implanted Cord/ Bladder Stimulator
- ☐ Arthritis in Hands
- ☐ Arthritis in Feet
- ☐ Plantar Fasciitis
- ☐ Sciatica
- ☐ Pinched Nerve
- ☐ Poor Circulation
- ☐ Joint Replacement
- ☐ Foot Surgery
- ☐ Poor Wound Healing
- ☐ Excessive Thirst or Urination

CENTRAL CLINIC OF CHIROPRACTIC

PRESENT HEALTH CONDITION

01 **In order of importance, list the health problems you are most interested in getting corrected:**

1. _____
2. _____
3. _____
4. _____

02 **Is there a certain time of day any of these problems are better or worse?**

_____
_____
_____
_____

03 **Is your balance/walking ability affected? If yes, please describe:**

_____
_____
_____
_____

04 **List approximately how long you have noticed these problems in your life:**

1. _____
2. _____
3. _____
4. _____

05 **Circle the things you have used for these problems:**

Gabapentin Neurontin Lyrica
Cymbalta Physical Therapy Pain
Medications Aleve Tylenol
Ibuprofen Motrin Chiropractic
Massage Therapy Injections Creams

06 **What do you think is causing your problem?**

_____
_____
_____
_____

07 **Name of all doctors you have seen for these problems and treatment you received**

_____
_____
_____
_____

CENTRAL CLINIC OF CHIROPRACTIC

08 **Have your symptoms:** Improved ☐ Worsened ☐ Stayed the Same ☐

List anything that makes your condition worse _____

_____

List anything that makes your condition better _____

_____

09 **How would you describe the symptoms? Please check ALL that apply:**

☐ Aching Pain	☐ Tingling/Electric Shocks	☐ Dead Feeling
☐ Stabbing Pain	☐ Pins & Needles Pain	☐ Cold Hands/Feet
☐ Sharp Pain	☐ Heavy Feeling	☐ Cramping
☐ Tiredness	☐ Hot Sensation	☐ Swelling
☐ Numbness	☐ Throbbing Pain	☐ Burning

10 **Is this condition interfering with any of the following?**

☐ Sleep	☐ Work	☐ Daily Activities
☐ Recreational Activities	☐ Walking	☐ Standing

SOCIAL HISTORY

Do you smoke? Yes ☐ No ☐ If yes, how many cigarettes daily? _____

Do you drink? Yes ☐ No ☐ If yes, how many drinks per week? _____

Do you exercise? Yes ☐ No ☐ If yes, please describe type and how often?

_____

CURRENT PAIN LEVELS

How would you rate your pain in the last week?

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST POSSIBLE PAIN

If you had to accept some level of pain after completion of treatment, what would be an acceptable level

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST POSSIBLE PAIN

PREVIOUS HEALTH CONDITIONS

This is a confidential record of your medical history and pertinent personal information. The doctor reserves the right to discuss this information with medical and allied health professionals per the informed consent. Copies of this record can only be released by your written authorization, unless you sign here indicating that we can release copies by your verbal request.

Name: _____ **Signature:** _____

Please give name, address, and office phone number of your primary care physician.

Name: _____ **Phone:** _____ **Address:** _____

When were you last seen there? _____

May we send them updates on your treatment/condition? Yes ☐ No ☐

List ALL allergies/sensitivities to medication, food, and other items here:

Items you react to:	Reaction:

List the prescription drugs you are currently taking (or you may attach a list):

Name	Dose (mg or IU)	Time Daily

List all nutritional supplements (vitamins, herbs, homeopathics, etc.) as above:

CENTRAL CLINIC OF CHIROPRACTIC

Patient Quality of Life Survey

Company Information: _____

Name: _____ **Date:** _____

Please take several minutes to answer these questions so we can help you get better.
(Please check all that apply)

01 How have you taken care of your health in the past?

- ☐ Medications
- ☐ Emergency Room
- ☐ Routine Medical
- ☐ Exercise
- ☐ Nutrition/Diet
- ☐ Holistic Care
- ☐ Vitamins
- ☐ Chiropractic
- ☐ Other (please specify): _____

02 How did the previous method(s) work out for you?

- ☐ Bad Results
- ☐ Some Results
- ☐ Great Results
- ☐ Nothing Changed
- ☐ Did Not Get Worse
- ☐ Did Not Work Very Long
- ☐ Still Trying
- ☐ Confused

03 How have others been affected by your health condition?

- ☐ No One Is Affected
- ☐ Haven't Noticed Any Problem
- ☐ They Tell Me To Do Something
- ☐ People Avoid Me

04 **What are you afraid this might be (or beginning) to affect (or will affect)?**

- ☐ Job
- ☐ Kids
- ☐ Future Ability
- ☐ Marriage
- ☐ Self-Esteem
- ☐ Sleep
- ☐ Time
- ☐ Finances
- ☐ Freedom

05 **Are there health conditions you are afraid this might turn into?**

- ☐ Family Health Problems
- ☐ Heart Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Depression
- ☐ Chronic Fatigue
- ☐ Need Surgery

06 **How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:**

_____

_____

_____

_____

07 **What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.). Give 3 examples:**

1. _____
2. _____
3. _____

08 **What are you most concerned with regarding your problem?**

09 **Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific.**

10 **What would be different/better without this problem? Please be specific.**

11 **What do you desire most to get from working with us?**

12 **What would that mean to you?**

Assignment of Payment and Treatment Authorization

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Central Clinic of Chiropractic will prepare any necessary forms to assist me in making collections from my insurance company. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, any outstanding charges for services rendered to me will be immediately due and payable. I agree that I will be responsible for all collection costs, attorney, and legal fees if legal action becomes necessary to collect this amount.

I hereby authorize the doctor to treat my condition as he/she deems appropriate through the use of chiropractic adjustments and other rehabilitation modalities. I hereby acknowledge that I have been informed that if x-rays are necessary, there will be a fee charged for those x-rays. The doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Signature_____ Date_____

Pregnancy

I verify my last menstrual period was _____ and that I am not pregnant, Central Clinic of Chiropractic has been informed of my condition and is not responsible for any future condition as a result of diagnostic x-rays.

Consent to Treat a Minor Child

I hereby authorize Central Clinic of Chiropractic to render any form of treatment of chiropractic as permitted by law and which in their sole discretion would benefit _____, a minor child.

Parent of Guardian Signature_____ ***Date***_____

APPOINTMENT CANCELLATION POLICY

This office requires **at least 24-hour notice** if you need to ***cancel*** or ***reschedule*** an appointment.

If you miss an appointment or cancel without 24-hour notice a $50.00 cancelation fee may be charged to your card on file.

Patient Signature: _____

HIPPA 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 PHI. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical health or mental health or condition, and related health care services.

Uses and Disclosures of Protected Health Information

Your PHI may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purposes of providing health care services to you, pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment

We will use and disclose your PHI 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, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment

Your PHI 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 PHI be disclosed to the health plan to obtain prior approval for the hospital admission.

Healthcare Operations

We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school 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 and indicate your physician. We may also call you by name in the waiting room when your physician in ready to see you. We may use or disclose your PHI as necessary to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situation 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, Coroner, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, 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 physician or the 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 PHI.

You have the right to inspect and copy your PHI. 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 PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction on your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your dare 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 physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI 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 physician amend your PHI. 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 PHI. We reserve the right to change the terms of this Notice and will inform you by mail of any changes. You then 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/before April 1, 2019.

We are required by law to maintain the privacy of, and provide individuals with, this Notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number.

Signing below is only acknowledgment that you have received this Notice of our Privacy Practices.

X_____