

APPLICATION FOR CARE AT CHIROPRACTIC PLUS, PC

PATIENT INFORMATION

Name: _____ Birth Date: ____/____/____ Age: _____ Male Female
 Address: _____ City: _____ State: _____ Zip: _____
 E-mail Address: _____ Home Phone: _____ Fax: _____
 Mobile Phone: _____ Work Phone: _____ Fax: _____
 Social Security #: _____ Driver's License #: _____ Employer: _____ Occupation: _____
 Name of Spouse: _____ Spouse's Employer: _____ Occupation: _____
 Names and Ages of your children: _____ Who referred you to our clinic?: _____
 Would you prefer reminders through Email or Text Messages? If Text Message please provide your Mobile Provider _____
(NOTE: If you are charged for incoming text messages, you will be responsible for any fees incurred.)

HISTORY OF COMPLAINT

Please identify if you came to this office, not as a result of a complaint, but for wellness care by completing the following:

Your Goals of Wellness Care: _____

Please identify, if any complaints, injury or illnesses that brought you to this office:

When did these problem(s) begin? _____ is your problem(s) the result of ANY type of accident. Yes No

If yes identify type: Auto Work Home Other (please explain): _____

Date of Accident: _____

Have you suffered with any of this or a similar problem(s) in the past? No Yes If yes when? _____

please state what type of treatment you has tried for this problem(s)

_____, and **who** provided it:
 _____ **when?** _____

What were the results? Favorable Unfavorable → please explain. _____

***PLEASE MARK** the areas on the Diagram with the following letters to describe your symptoms:

- R = Radiating B = Burning D = Dull A = Aching N = Numbness**
S = Sharp/ Stabbing T= Tingling

What percentage of the day do you experience your symptoms: _____%

What relieves your symptom(s)? _____

What makes them feel worse? _____

Have you had previous chiropractic care? Yes No

Name of Previous Chiropractor: _____

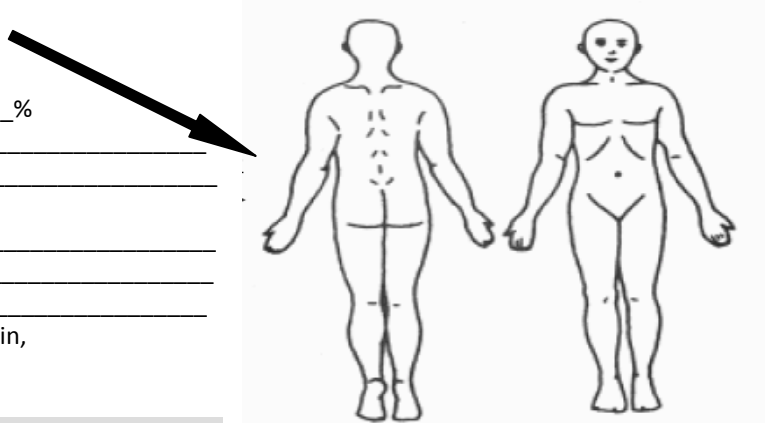
How long were you under care: _____

What were the results? _____

On a scale of 1 to 10 with 10 being the worst pain and 0 being no pain,

rate how you feel today (**Circle the number**):

0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10



PAST HISTORY

If you have ever been diagnosed with any of the following conditions please indicate with a **P** for in the **Past**, **C** for **Currently** have and **N** for **Never** have had a: Disability Broken Bone Fracture Dislocations Tumors Rheumatoid Arthritis Osteo Arthritis Cerebral Vascular Heart Attack Diabetes Other serious conditions: _____

PLEASE, identify ALL PAST and any **CURRENT** conditions you feel may be contributing your present problem: _____

SOCIAL HISTORY

1. Smoking: cigars pipe cigarettes → How often? Daily Weekends Occasionally Never

2. Alcoholic Beverage: consumption occurs → Daily Weekends Occasionally Never

3. Recreational Drug use: Daily Weekends Occasionally Never

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s) you currently have? No Yes **If yes whom:**

grandmother grandfather mother father sister's brother's son(s) daughter(s)

Have they ever been treated for their condition? No Yes I don't know

2. Any other hereditary conditions the doctor should be aware of. No Yes: _____

I hereby authorize payment to be made directly to Chiropractic Plus, PC, for 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 Chiropractic Plus.

Patient or Authorized Person's Signature

Date

File # (clinic use)



NOTICE OF HIPAA PRIVACY PRACTICE

Chiropractic Plus, PC is required to notify you writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which by law, or as dictated by - our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled 'HIPAA' on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care.
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any available collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation.
5. Emergency- in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent to or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -we may call your home and leave messages regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Spouses, household partners and other close family members.
12. Change of ownership- in the event this practice is sold the new owners would have access to your PHI

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information, however like restrictions we are not required to agree to them

COMPLAINTS:

If you wish to make a formal complaints about how we handle your health information please call Marilyn Flores at 281-345-8800 If she is unavailable, you may make an appointment with our receptionist to see her within 2 working days. If you are still not satisfied wit the manner in which this office handles your complaint, you can submit a formal complaint to: Chiropractic Plus, PC, 4500 D. Highway 6 N, Houston, TX 77084

Note: This office reserves the right to amend this notice of privacy practice at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I have received a copy of Chiropractic Plus, PC Patient Privacy Notice and understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding to the doctor. I understand that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient signature

Date

Witness

Date



CHIROPRACTIC PLUS, PC POLICIES

Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe first hand the positive results that are achieved and the benefits derived from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

PATIENT PRIVACY – Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. You consent to any perceptions others may have regarding your open bay treatment. If you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance

YOUR CARE - When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at Chiropractic Plus, PC is rendered primarily to eliminate subluxations, which are a major interference to the expression of the body’s God-given, innate wisdom. The doctors use a myriad of techniques to accomplish this goal, including but not limited to Gonstead, Diversified, Pettibon, etc. 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 will take you beyond simple pain relief, through three distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving you overall health. Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostic may also be ordered, to confirm the true nature and exact location of subluxations. These procedures are performed to assess your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining chiropractic amenability, as well as the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do to maintain their health for a lifetime.

PATIENT WORKSHOPS – To enhance your understanding of the therapeutic, as well as maintenance care you will be receiving, you will be required to attend our Doctor’s Report within the next 5 days. The information you receive will be both informative and stimulating. Afterwards you will consult privately with the doctor to discuss your x-rays and exam results as well as recommendations for care.

REFERRING TO SPECIALTY PROVIDERS - We do not offer to diagnose or treat any diseases or condition other than vertebral subluxations. If during the course of your spinal examination, the doctor discovers an unrelated problem, you will be advised to seek a consultation with another specialty provider. Chiropractic is drugless treatment. If together we have a goal of getting off prescription medication, it is your responsibility to do so with the assistance of your medical prescriber.

FREQUENCY AND DURATION OF CARE Adults: While pain relief may take only a few visits, getting well takes time. Generally speaking, a patients age and life style along with the severity of the accompanying symptoms, and the length of time the condition has existed, will play a large role in determining the frequently and duration of their care. The longer the subluxation has existed the more the damage, and the longer it will take to achieve correction and stabilization which takes place during the final phases of a care plan; a goal which is integral to maintaining a healthy spine and nervous system.

Children: Young 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 subluxations; therefore, it is best to check children for subluxations and begin any necessary care as young as infancy. It is the policy of this practice to provided spinal check-ups to children up to 18 years of age at no charge.

CARE PLAN INTERRUPTIONS – In order to complete your first phase of care in the least amount of time with maximum results, it is vital that you follow the recommended clinical course of care outlined by your doctor without exception. That means if you miss an appointment, you must reschedule that appointment for the same or next day. If you are going on vacation or out of town for an extended period of time please let the doctor know so we can provide you with additional instructions regarding the care of your condition.

TREATING DOCTOR IN CHARGE OF YOUR CASE - Like all professions chiropractors are required to attend continuing education classes for license renewal every year. Additionally Dr. Phillip Barnwell may be called out of town to a conference. Although Dr. Phillip Barnwell will not be available to adjust /treat patients during his/her absence another qualified doctor, familiar with your case will be managing your care until the doctor returns. It is the policy of this practice to ensure all active patients a continuum or uninterrupted care.

DISCONTINUING CARE – Should you decide AT ANY TIME to discontinue care in this office, you must speak to Dr. Phillip Barnwell directly, so that an appropriate assessment as to the status of your health that day, can be made, and documented in your record. This is particularly important should be injured in an accident in the future and a baseline for liability becomes necessary. Additionally if you have a credit balance on your account, and would like a refund. It is the policy of this practice to refund patients any outstanding credit balance on their account within 30 days of discontinuing. If it is done against the doctors advise you will be required to speak to the doctor personally, or submit to the office, a written statement explain your reason(s) for discontinuing care. Refunds of any credit balance is determined by averaging the cost per patient visit over the entire prepaid package and refunding any unused visits.

HOLIDAYS AND OFFICE VISITS AFTER HOURS –our office hours are by appointment. If you are involved in an accident or need to be seen for any other emergency ON A WEEKEND OR HOLIDAY. WE WILL BE HAPPY TO SEE YOU, However, you or your insurance will be charged at our full visit rates and the prepaid plan discounts will be suspended until the treatment for the accident or emergency end.

FEES & PAYMENT FOR SERVICES - Fees for services are due at the time services are rendered. We have many options for patients to make payment. Pay Entire Plan, Monthly, and post dated checks. If you have network insurance and are receiving wellness treatment, you acknowledge that your insurance does not cover your wellness treatment and you instruct us to not bill your insurance.

BILLING INSURANCE – We ask our patients to please understand that health and accident insurance policies are a contract between them and their insurance company. We are happy to assist our patients in filing claims for reimbursement and will accept any amounts authorized by a patient to be paid directly to Chiropractic Plus, PC. **However it must be clearly understood** that all services rendered are charged directly to the patient and that patients are ultimately, personally responsible for payment.

CARING FOR YOUR FAMILY - it is the policy of this practice to offer the families of all new patients the opportunity to be evaluated by Dr. Phillip Barnwell at no charge as long as the appointment is made within 10 days from the date of your first visit.

CONSULTATIONS - it is the policy of this practice to offer complimentary consultations to first time new patients.

Patient
Signature: _____ Date: _____



CONSENT TO TREAT A MINOR

MINOR PATIENTS' NAME: _____

The risks associated with exposure to ionization, and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor, and after careful consideration I do hereby request, and authorize Chiropractic Plus, PC to perform imaging studies, and chiropractic adjustments, to my minor child, for whom I have the legal right to select, and authorize health care services on behalf of.

Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse /former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way I will immediately notify this office.

Parent /Legal Guardian

Date

Witness

Date



CHIROPRACTIC PLUS, PC MEDICARE POLICY

CHIROPRACTIC PLUS, PC IS A PARTICIPATING PROVIDER

This means that we have agreed to accept assignment and receive payment from Medicare for those services considered eligible by Medicare for reimbursement. At this time Medicare’s chiropractic coverage is limited to non-wellness manual manipulation of the spine. No other services will be paid for by Medicare. Before Medicare will consider reimbursement of a spinal manipulation, the doctor must verify the existence of a subluxation. Subluxations are demonstrated through the use of plain film radiography or performance of a specific examination. Because neither of these services are eligible for Medicare reimbursement. it is the policy of this practice to collect those fees at the time of service, from the Medicare beneficiary.

Additionally all Medicare patients are required to pay 100% of their charges up to \$155.00 to satisfy an annual Medicare deductible. If you feel you have met this deductible, please indicate by checking the box below. There is also a co-payment of approximately \$6.99 which we collect from you at the conclusion of each visit.

If you have a Medicare supplement or secondary insurance, please notify us immediately so that we can include all necessary information on your Medicare claim form. Medicare will, in most instances automatically submit all charges and an explanation of the benefits they paid to your secondary or supplement insurance. A Medicare supplement should reimburse the amount of the co-payment and a secondary insurance plan may reimburse services such as examinations –x-rays and or any other service Medicare considers ineligible which you are required to pay. Finally, Medicare does not impose a limit on the amount of chiropractic care that a beneficiary may receive per say, however they do routinely audit providers practices to ensure a very strict **“Medical Necessity” Policy**. This means that a Medicare patient’s Chiropractic Care is only eligible for reimbursement if there is evidence of a significant health condition that presents with active symptoms, and it is reasonable to expect that the care rendered will bring about considerable improvement in the patients condition so that full function is restored within a relatively short predictable period. When patients have achieved maximum clinical improvement , care aimed at maintaining or preserving a level of achieved functionality, or to prevent regression, or promote and enhance a quality of life will not be paid for by Medicare. **Once you have reached this point in your care, before any further care is rendered you will be consulted so that you can make an informed decision as to whether you wish to continue chiropractic care, in as much as** you will then be responsible for the full cost of your care each visit thereafter. Unless you experience a new injury , condition or symptoms all further care is classified as “maintenance ’ which Medicare deems “medically unnecessary”

I understand the limits Medicare imposes with regard to chiropractic care and that I am responsible to pay all fees for services Medicare does not cover.

Patient signature

Date

Patients’ Name : _____

DOB: _____

FILE#: _____