Last Name _____ First _____ Middle In. _____ Date _____

Address _____ City _____ State _____ Zip _____

Home Phone (____)_____ Work Phone (____)_____ Cell Phone (____) _____

E-mail _____ (used for appt reminders and correspondence)

Occupation _____ Employer _____ Hours per week worked _____

D.O.B. ____/____/_____ Age _____ Social Security # _____ ❑ Male ❑ Female ❑ Married ❑ Single

Emergency Contact _____ Ph.# _____ Relationship: _____

Family Doctor _____ Phone #_____ Last Exam Date _____

What is your main complaint(s)? _____

Is condition: □ Job related □ Auto Accident □ Home Injury □ Fall □ Unknown □ Other _____

Circle the INTENSITY of your PAIN when present (0=no pain, 10=severe pain): 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Mark the FREQUENCY of your PAIN: □ Constant (75-100%) □ Frequent (50-75%) □ Occasional (25-50%) □ Intermittent (0-25%)

Describe the Pain (mark all that apply): □Dull, □Sharp, □Ache, □Throb, □Burning, □Numb, □Tingling, □Cramping, □Spasm, □Shooting

Other Conditions in past 6 weeks: □ Headaches, □ Neck Pain, □ Shoulder pain (R - L), □ Pain between shoulders, □ Low back pain, □ Buttock Pain (R - L), □ Hip Joint Pain (R - L), □ Arm/hand numb/tingle (R - L), □ Leg/foot numb/tingle (R - L)

Financial Release and Assignment:
Payment is expected on the date that services are rendered. Insurance filing is a courtesy for our patients. Balance for services is the patient responsibility. I understand any outstanding accounts beyond 60 days may result in a 2% finance charge per month. If the account is sent to collections, any fees associated with the collection of charges will also be billed to the patient (according to Collection Agency fee amounts). I authorize the release of any information necessary to process my insurance claims and request payment be sent directly to my physicians.

X-ray Consent:
The purpose of the x-ray examination to be performed is to analyze the spine for evidence of vertebral subluxation, rate and level of degeneration of the spine, and to determine the appropriateness of spinal adjustments. If the doctor discovers a non-chiropractic "unusual finding" when reviewing the x-rays, I will be informed. With the help of the doctor, I thus must determine if I should seek the services of an additional healthcare provider for advice, diagnosis, or treatment of the unusual finding. I understand that seeking advice from another healthcare provider will likely not interfere with the subluxation correction care provided by this office. I fully understand the above and consent to chiropractic spinal x-rays.

****WOMEN ONLY - Pregnancy Release:** This is to certify that to the best of my ability I am not pregnant and I give my permission to perform an x-ray evaluation. I understand the risks of an x-ray to an unborn child. □ **I am or may be pregnant** □ **I am <u>NOT</u> pregnant**

Consent to Receive Chiropractic Care:
I, the undersigned, give this office and its doctor(s) permission and authority to provide care in accordance with standard chiropractic tests, analysis, diagnosis, and treatment. Chiropractic care seldom causes complications, but in rare cases, due to underlying physical defects, deformities, or pathologies may render a patient susceptible to injury. The doctor(s) will not provide care, without consent of the patient, if they are aware of any contraindication that my be present. It is the responsibility of the patient to discuss with the doctor(s) any known underlying deformities or defects that may not otherwise come to the attention of the doctor. I do not expect the doctor(s) to be able to anticipate and explain all risks and complications and I wish to rely on the doctor(s) to exercise judgment during the course of the procedure which the doctor(s) feels at the time, based upon the facts then known, is in my best interests.

HIPAA Privacy Rule: This office is required by law to maintain the privacy and confidentiality of your protected health information. By signing this form, I release this office from all liability and give permission to use my first and last name for the purpose of speaking with me in the presence of others. I understand that I may request a detailed copy of the HIPAA privacy rule at any time.

I have read and fully understand the above statements and accept chiropractic care on this basis.

Patient/Parent/Advocate Signature: _____ Date: _____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature:_____ Date:

Witness Name: _____ Signature:_____ Date:

Elite Spine, PC

Health Insurance Election Form

(Accident and Non-Accident Cases)

How would you like for us to handle your health insurance? Please choose one:

☐ **Option 1 -- I Do Not Have Health Insurance / I Don't Want You to File My Health Insurance**

I want the services we discuss, but either I don't have health insurance or I don't want you to bill or submit paperwork to my health insurance. You may keep any health insurance which I may have and that I provide to you on file, but only for the purposes set forth in, and as consistent with, your Financial Policy. I understand that if my claims or forms are not submitted to my health insurance in a timely manner, my payer may decline to pay on my claims and I may not be able to appeal this decision.

☐ **Option 2 -- I Want You to File My Health Insurance and Also to Help Me Verify My Benefits. To Help You Get Paid, I'll Make Partial Payments and/or Sign an Assignment & Financial Policy**

I want the services we discuss, but I also want you to bill my health insurance for an official decision on payment. Please help me verify any Terms of Non-Coverage. If I have any questions, I will verify my coverage on my own. You may ask to be paid now for estimated co-pays, co-insurance, deductibles and other Non-Covered amounts. I understand that these are just estimates. In the event that my health insurance delays or Denies Payment, I will be responsible for payment as described in your Financial Policy, but I understand that I will be able to appeal to my health insurance following its directions.

☐ **Option 3 -- I Want You to File My Health Insurance, But I'll Pay in-Full at the Time of Service or Pre-Pay. If Insurance Pays, You'll Give Me a Refund**

I want the services we discuss, but I also want you to bill my health insurance for an official decision on payment. However, you may ask to be paid now. If my health insurance does pay, you will refund any payments I made to you, less co-pays, co-insurance, and deductibles, and also discounts (Mandatory Fee Reductions) as described in your Financial Policy. In the event that my health insurance Denies Payment, I can appeal to my health insurance following its directions.

Important: I understand that in certain circumstances, the Office may have a policy of not filing health insurance or law may actually control or regulate the filing of insurance. This election will remain in effect until a new election is signed with the Office's consent. This election supersedes any prior health insurance election.

Patient Name: _____ Date: ____/____/_____

Patient Signature: _____

FINANCIAL POLICY AND AGREEMENT – Elite Spine, PC

I, the undersigned, in consideration of the Office's services, agree to the following terms:

Definitions. In this Agreement, "Office" and "Clinic" shall refer to **Elite Spine, PC** dba of Simply Chiropractic located at **7465 E 82nd St, Indianapolis, IN 46256**. "Financial Policy" or "Agreement" shall refer to this document.

Authorization to Sign My Name on Payments; Transfer of Credit Balances. I authorize the Office to endorse or sign my name on any and all payments listing me as a payee which are received by the Office for payment of Charges incurred by me, my spouse or my dependents. In such cases, my printed name, followed by the phrase, "(by [Name of Office])," shall serve as a properly authorized endorsement. I further authorize the Office to apply any credit balances on my Charges to any other outstanding Charges still owed by me, my spouse, or my dependents, regardless of whether these other Charges are related to my condition.

Personal Responsibility for My Charges. I understand that I remain personally responsible for my Charges and that at any time, I can request a copy of my total Charges from the Office. Except where provided otherwise by law or by contract, I agree to pay the full amount of my Charges to the Office promptly upon its demand. I understand that the Office's Assignment does not constitute an agreement by the Office to await payment of my Charges. I agree that any delay by the Office in making demand for payment, any delay in paying the full amount of my Charges, and any partial payments received by the Office towards my Charges, shall not constitute acceptance of any installment payment plan, shall not constitute a waiver of the Office's right to receive payment-in-full promptly upon demand, and shall not constitute an "accord and satisfaction" of my Charges, regardless of any such terms or restrictions indicated on, or included with, any payments. I also agree that my account with your Office shall be construed as in "default" on the earlier of the following dates: (a) a Payer fails to pay any or all of the Charges in-full and directly to the Office upon receipt of those Charges within thirty (30) days or the period established by the earliest prompt pay deadline applicable to the Payer (whichever occurs later), (b) I do not pay any or all of the Charges in-full within fourteen (14) days of request, or (c) the Office attempts to charge my credit card in compliance with a written Payment Arrangement, but the charge is declined or not approved.

Personal Responsibility for Verifying the Limitations in My Coverage; Financial Responsibility for Non-Covered Charges. I understand that in any given situation, a Payer may initially refuse to make payment to the Office, may delay payment for an indefinite or unreasonable amount of time, or may actually request a refund from the Office after making payment, and do so either in whole or in part with respect to any given Charge incurred at the Office (collectively, "Deny Payment"). For example (without limiting this Agreement), I understand that a Payer may Deny Payment, stating that the Charge is "not a covered benefit" under its policy or exceeds some other limitation. I further understand that a Payer may Deny Payment stating that the individual provider who actually renders the treatment or procedure is out-of-network. I also understand that a Payer may claim, based on internal criteria, that a particular Charge is or was not medically necessary or was not sufficiently documented, and should therefore be denied or downcoded. I also understand that a Payer may require certain Charges to be pre-certified or pre-authorized. In the event that my condition arose from an accident, I further agree to the terms of the Office's Auto / Work Comp Advance Beneficiary Notices as applicable. I understand that there may be many other situations where a Payer may Deny Payment based on a particular contractual term applicable to me or to the Office (collectively, "Terms of Non-Coverage"). To the extent permitted by law or by contract, I agree that I am solely and exclusively responsible for verifying all Terms of Non-Coverage prior to incurring any Charges at the office. I agree that if I have any questions about the Terms of Non-Coverage, I can request copies of the Office's verification (e.g., eligibility, pre-authorization) forms to gain further understanding. I agree that should the Office assist me in any way in the verification, pre-authorization, or billing process, I assume the risk that the Payer and/or the Office may in my opinion not accurately understand and/or communicate the Terms of Non-Coverage and/or bill my Charges to my Payers. Should any Payer Deny Payment, or should any Payer be likely to Deny Payment as determined by the Office in its sole discretion, I agree that I am personally, fully, and immediately responsible for the portion of my Charges denied or likely to be denied. In no event shall I hold the Office responsible or liable in any of the foregoing instances.

Direction to the Office to Apply the Lowest Mandatory Fee Reduction When Two or More Payers Are Involved. Unless otherwise agreed to in writing, I authorize the Office to submit my Charges, as well as a copy of the Assignment & Lien, to any and all Payers, not including in accident cases my health benefit plan or Medicare. Notwithstanding the foregoing, in the event that the Office determines in its sole discretion that it has any reasonable basis for either submitting or not submitting my Charges and/or other documentation to a Payer, I hereby authorize the Office to take such action without condition or restriction. I understand that some or all of these Payers may utilize fee schedules which (a) the Office has agreed to accept, directly with said Payers in writing, or (b) law expressly imposes on the Office to accept (collectively, "Mandatory Fee Reductions"). I further understand that the Mandatory Fee Reductions imposed on the Office with respect to one Payer may exceed the Mandatory Fee Reductions imposed on the Office with respect to another Payer. In such an event, I hereby authorize and direct the Office insofar as permitted by law to apply the lower of the two Mandatory Fee Reductions to its Charges. I further agree that in the special event that Mandatory Fee Reductions are imposed on the Office by virtue of laws which regulate or restrict "balance billing," I hereby waive the application of such laws to the extent permitted by law. In the event that no Mandatory Fee Reductions are actually imposed on the Office with respect to a Payer, I authorize and direct the Office to collect up to its full Charges from such Payer.

Miscellaneous Provisions. Except as provided in this paragraph, this Agreement shall not be modified or revoked without the expressed, written consent of the Office. I hereby revoke, with the Office's consent, the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this Agreement. I agree that each and every provision of this Agreement is reasonably necessary. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect. This Agreement shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. In any action based upon this Agreement, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum inconvenience. I further waive any statute of limitations which may apply in any action based upon this Agreement. I have reviewed the Office's "Assignment & Lien", Health Insurance Election, and, if applicable, Auto / Work Comp Advance Beneficiary Notices, and further agree to the terms and definitions set forth in these documents as applicable. Said documents are incorporated herein by reference. In the event that my condition is related to an accident, including without limit automobile accident, I understand that there will be an administrative fee necessary to cover the costs of verifying multiple Payers, filing and terminating liens, and submitting notices of same to Payers.

I have read, understood, and agree to the terms of this Agreement.

Patient Name (print): _____ Patient Signature: _____ Date: ____/____/____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (please print): _____

Parent/Guardian Signature: _____ Date: ____/____/____