Fletcher Chiropractic - Confidential Patient Information

Last, First Name	DOB	Age	Sex	Marital Status

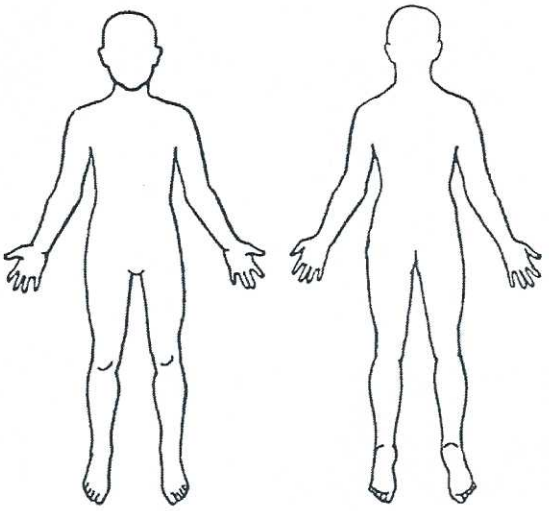
Address	City	State	Zip Code

( ) Home phone	( ) Cell Phone	E-mail Address

Social Sec#	Occupation	Company Name/Location	Phone#

Guardian/Spouse's name	Guardian/spouse's DOB	Guardian/spouse's SS#	Guardian/spouse's employer

On the diagram to the right mark with an X where you are experiencing symptoms.



Your present complaint(s) _____

_____

_____

_____

_____

_____

Who referred you to/ how did you hear about our office?

_____

Will this be a part of a claim for: Car Accident (PI)_____ or Worker's Comp Claim _____?

Emergency Contact: _____ **Relationship:** _____ **Phone: (___)**_____

List other doctor(s) seen for this condition _____

Have you ever had chiropractic care? Yes_____ **No**_____ **Date of last adjustment**_____

Have you ever had massage therapy? Yes_____ **No**_____ **Date of last massage**_____

List any operations you've had and the dates: _____

Have you been treated by a physician for any health conditions in the last year? Yes_____ **No**_____

Describe condition _____ **Date of last physical exam** _____

Are you now taking any medication? Yes_____ **No**_____ **List:** _____

Are you pregnant? Yes_____ **No**_____ **Date of last menstrual period** _____

Do you have insurance? Yes_____ **No**_____ **Company** _____

Primary Care Physician_____ **Location**_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if Fletcher Chiropractic extends credit to me and I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made. I hereby authorize the doctors at Fletcher Chiropractic and whomever they may designate as their assistants to administer treatment as they so deem necessary. I certify that the above information is true and correct.

Patient's (Guardian's) Signature _____

The following is an explanation of our office policies. We believe that a clear understanding will allow us both to concentrate on the most important issues; regaining and maintaining your health. We will be happy to answer any questions you may have regarding our policies, your account or insurance coverage.

Complimentary Consultation

Fletcher Chiropractic will conduct a special "no charge" consultation, or brief conference, with anyone interested in finding out if chiropractic can help them with their individual health problem. There is no charge or obligation in connection with this appointment.

Patient Payment Policy

We feel the patient's health needs are paramount. Therefore, the following Patient Care Services policy is an attempt to allow you, the patient, to receive the care you need and clear your balance with the least amount of difficulty.

Patient Care Services

Payment in full for all services is due at the time of service unless other arrangements have been made. Payment arrangements may be made with the office and payments must be made no less than monthly. Please understand that all services rendered to you are charged directly to you and you are responsible for payment, regardless of your insurance coverage. Properly documented Worker's Compensation and auto accident claims are not required to pay at the time of service if appropriate forms and liens are signed.

Our Policy on Health Insurance

Many insurance policies cover chiropractic care. We will be happy to file your insurance claim for you and do everything we can to ensure you receive reimbursement. However, we cannot take responsibility for what your health insurance will or will not cover. It is important that you understand that health and accident insurance policies are an arrangement between an insurance carrier and you the patient, their insured. Of course, Fletcher Chiropractic will prepare any necessary reports and forms to assist you in collecting from your insurance company. Furthermore, any amount authorized to be paid directly to Fletcher Chiropractic will be credited to your account upon receipt.

Identification Policy

Fletcher Chiropractic requires a copy of photo identification (ex: driver's license, passport, student ID) be on file in order to receive care.

Questions and Answers

Your questions about any aspect of your care or account are invited. Please feel free to ask the Doctor or any available staff member. We will make every effort to answer and address your concerns.

I have read the Fletcher Chiropractic clinic policies and agree to honor them:

Print:	**Sign:**
Date:	

Fletcher Chiropractic - Notice of likelihood of insurance denial of benefits

I understand that my insurance company may deny payment for the service provided to you for the following reasons:

That the particular service is not reasonable and/or necessary under my insurance companies standards or considered experimental.

For this reason, please read and sign the following statement:

"I have been informed by my physician that he/she believes that, my particular case, my insurance may deny payment for the services identified above, for the reasons stated. If my insurance denies payment I agree to be personally responsible for payment of said services."

Print:	**Sign:**
Date:	

ASSUMPTION OF FINANCIAL RESPONSIBILITY

****Explanation of benefits disclaimer****

I, the undersigned patient, completely understand that Fletcher Chiropractic provides insurance billing and insurance benefit verification as a courtesy to their patients. I understand that the service Fletcher Chiropractic provides for verification of insurance coverage is in no way a promise of payment by my insurance company. If my insurance company denies my claim(s) for any reason, or misquotes my benefits to Fletcher Chiropractic, the balance of my account will be billed to me and due to the clinic.

It is the policy of Fletcher Chiropractic to never enter into a dispute with your insurance company for any reason.

I, the undersigned patient, completely understand the insurance services provided to me regarding my insurance coverage as stated above. I understand that my signature below serves as a "signature on file" to bill the above insurance company and allows this clinic to accept assignment of insurance benefits. I understand the above "Benefits Disclaimer" and my financial responsibilities to any services rendered by this clinic. I understand that Fletcher Chiropractic, PS may have a contract with my insurance company that allows only co-pays to be collected at time of service. By signing this form, I am agreeing to pay any co-pay, deductible and coinsurance at time of service. This may offer a reduced fee for paying at the time of service rendered.

Print:	**Sign:**
Date:	

Fletcher Chiropractic Center keeps a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Fletcher Chiropractic.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

You may refuse to sign this acknowledgement
By my signature below I acknowledgement receipt of the Notice of Privacy Practices

_____

Patient or legally authorized individual signature Date Time

_____

Printed name if signed on behalf of patient Relationship

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) _____

Additional Disclosure Authority

In addition to the allowable disclosures describe in the "Notice of Privacy Practices", I hereby specifically authorize disclosure of my protected health care information to the person indicated below.

Any member of my immediate family: Yes_____ No_____
Spouse Only: Yes_____No_____
Other: (Please Specify)_____Yes_____ No_____
My Designated Primary Care Provider: Yes_____No_____

Signature: _____ Date:_____

Fletcher Chiropractic Center - Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW CHIROPRACTIC INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Fletcher Chiropractic Duties:
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We're also required to abide by the privacy policies and practices that are outline in this notice.

Uses and Disclosures:

Treatment: Your health information may be used to seek payment from your insurance plan or credit card companies that you may use to pay for services. For example, your insurance plan may request and receive information on dates of service, the services provided, and the condition being treated.

Health Care Operation: Your health information may be used to support the day-to-day activities and management of **Fletcher Chiropractic.** For example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality, to insure that our practice is meeting state and federal guidelines and laws designed to protect your health care information.

Law Enforcement: Your health information may be disclosed to law enforcement agencies without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandate reporting as required by law.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, our practice is required to report certain communicable diseases and acts of abuse to state agencies.

Other Uses and Disclosures Require Your Authorization: Disclosure of your information or its use for any purpose other than those listed above requires your specific written authorization. Examples include disability forms and any letter that you request for your employer or other entity. If you change your mind after authorizing a use or disclosure of information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified our office of your change in decision.

Additional Uses of Information:

Information About Treatments: Your health information may be used to send you information on the treatment and management of your chiropractic condition that you may find to be of interest.

Appointment Reminders: Your health information will be used by our staff to send you postcards, e-mails, texts, or to call to let you know of a missed appointment and to remind you to make an appointment for a visit.

Events: Your health information will be used to remind you of upcoming events in our office.

Individual Rights
You have certain rights under the federal privacy standards. These include:
- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your chiropractic condition and treatment.
- The right to inspect and copy your protected health information.

• The right to receive an accounting of how and to whom your protected health information was disclosed.
• The right to receive a printed copy of this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next visit. The revised policies and practices will be applied to all protected health information that we maintain.

Request to Inspect Protected Health Information
As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our receptionist.

Complaints and Contact Person
If you would like to submit a comment or complaint about our privacy practices, or obtain additional information about our privacy practices, you can do so by sending a letter outlining your concerns to the address listed below.

You will not be penalized or otherwise retaliated against for filing a complaint.

Privacy Officer
Fletcher Chiropractic
5246 N Eagle Rd.
Boise, ID 83713
208-939-3000

This Notice is effective on or after January 1, 2003.

A. Notifier: Fletcher Chiropractic Center, 5246 N Eagle Rd., Boise, ID 83713

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D. 1, 2, 3 or 4** below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
1.Chiropractic Adjustment 2.Xrays 3.Chiropractic Examination 4. Ancilliary services/therapeutic modalities or exercise equipment	1. Medicare may determine this service is not "reasonable and necessary" under Medicare program standards. 2. Not a covered service under Medicare Part B 3. Not a covered service under Medicare Part B 4. Not a covered service under Medicare Part B	1. $55 2. $70-$210 3. $45-75 4. $25-$50

WHAT YOU NEED TO DO NOW:

Read this notice, so you can make an informed decision about your care.
Ask us any questions that you may have after you finish reading.
Choose an option below about whether to receive the **D.** *1, 2, 3 or 4* listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** *1, 2, 3 or 4* listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** *1, 2, 3 or 4* listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.** *1, 2, 3 or 4* listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) 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. RESERVED FOR NUCC USE

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. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

PATIENT AND INSURED INFORMATION

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 ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

	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. Rsvd for NUCC Use

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. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.