Confidential Patient Health Record/ Cedar Chiropractic & Sports, 77 West Main St. Hopkinton MA

Today's Date: _____ / _____/_____

How did you hear about us? □ Family _____ □ Friend _____ □ Co-Worker _____ □ Close to home/work □ Dr. _____ □ Yellow Pages □ Drove By □ Hospital □ Insurance Plan □ Website: _____

Personal Information

Last: _____ First: _____ Middle: _____

Birth Date: ____ / ____ / _____ Age: ____ Sex: M / F SSN: _____ Marital Status: □ S □ M □ W □ D

Height: _____ Weight: _____ □ R □ L Handed □ Glasses □ Contact Lenses

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ ext: ____ Work Phone: (_____) _____-_____ ext: ____

Cell Phone: (_____) _____-_____ ext: ____ Email Address: _____

Spouses Name: _____ Children (Names & Ages): _____

Emergency Contact

Last: _____ First: _____Relationship: □ Spouse □Relative □Friend □Other_____

PRIMARY CARE PHYSICIAN: _____

Home Phone: (_____) _____-_____ ext: ____ Work Phone: (_____) _____-_____ ext: ____

Cell Phone: (_____) _____-_____ ext: ____

Employment Information

Business Name: _____

Phone: (_____) _____-_____ ext: ____ Fax #: (_____) _____-_____

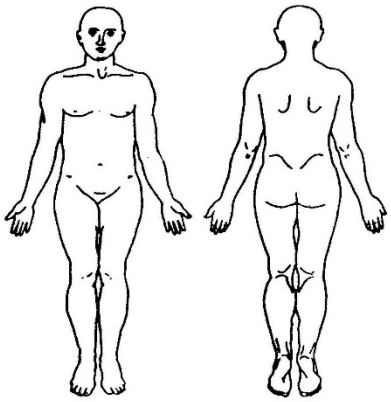
Occupation / Job Title / Description: _____

Current Health Condition

Unwanted Condition (Why are you here today?) _____

PLEASE INDICATE ON THE DIAGRAM THE AREA OF DISCOMFORT:

Key: A=Ache B= Burning N=Numbness P=Pins & Needles S=Stabbing



When did this Condition BEGIN? _____ / _____ / _____

Has it ever occurred before? □ Yes □ No. When? _____

Is the Condition: □ Auto Related □ Job Related □ Home Injury □ Slip or Fall □ Lifting □ Slept Wrong □ Unknown Cause □ Other

Explain: _____

Date of Accident: _____ Time of Accident: _____ am/pm

Condition / Pain STARTED on what DATE: _____

Do you have any other health concern? _____

Patient Name: _____ DOB: ____ / ____ / _____ Date: _____

REVIEW OF SYSTEMS – Below is a list of symptoms that may be seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

Constitutional: □ I **DENY** having or have had any of the symptoms or problems listed below.

□ chills □ fatigue □ night sweats □ weight loss □ daytime drowsiness
□ fever □ weight gain □ other: _____

Eyes / Vision: □ I**DENY** having any of the symptoms or problems listed below.

□ spots □ change in vision □ trauma □ photophobia □ blurred vision
□ glaucoma □ double vision □ tearing □ cataracts □ wear glasses/contacts
□ itching □ eye pain □ other: _____

Ears, Nose and Throat: □ I **DENY** having any of the symptoms or problems listed below.

□ bleeding □ ear drainage □ hearing loss □ nosebleeds □ sore throat
□ dentures □ ear pain □ history of head injury □ postnasal drip □ TMJ problems
□ difficulty swallowing □ fainting □ hoarseness □ rhinorrhea (runny nose) □ tinnitus (ringing in ears)
□ discharge □ frequent sore throat □ loss of sense of smell □ sinus infections □ other: _____
□ dizziness □ headaches □ nasal congestion □ snoring _____

Respiration: □ I **DENY** having any of the symptoms or problems listed below.

□ asthma □ coughing up blood □ sputum production □ cough □ shortness of breath □ wheezing □ other: _____

Cardiovascular: □ I **DENY** having any of the symptoms or problems listed below.

□ angina (chest pain or discomfort) □ high blood pressure □ low blood pressure
□ chest pain □ heart problems □ swelling of legs
□ claudication (leg pain/ache) □ ulcers □ orthopnea (difficulty breathing lying down)
□ heart murmur □ palpitations □ varicose veins
□ shortness of breath with exertion or exercise □ paroxysmal nocturnal dyspnea (waking at night with shortness of breath)
□ other: _____

Gastrointestinal: □ I **DENY** having any of the symptoms or problems listed below.

□ abdominal pain □ diarrhea □ indigestion □ vomiting blood □ abnormal stool consistency
□ jaundice □ heartburn □ nausea □ constipation □ abnormal stool color
□ difficulty swallowing □ hemorrhoids □ vomiting □ rectal bleeding □ black tarry stools
□ belching □ other: _____

Female: □ I **DENY** having any of the symptoms or problems listed below.

□ birth control □ cramps □ irregular menstruation □ vaginal bleeding
□ breast lumps / pain □ frequent urination □ pregnancy □ vaginal discharge
□ burning urination □ hormone therapy □ urine retention □ other: _____

Male: □ I **DENY** having any of the symptoms or problems listed below.

□ burning urination □ frequent urination □ prostate problems □ other: _____
□ erectile dysfunction □ hesitancy □ urine retention

Endocrine: □ I **DENY** having any of the symptoms or problems listed below.

□ cold / heat intolerance □ excessive hunger or thirst □ goiter □ unusual hair growth □ other: _____
□ diabetes □ frequent urination □ hair loss □ loss / change in appetite

Patient Name: _____ DOB: ____ / ____ / _____ Date: _____

Skin: □ I **DENY** having any of the symptoms or problems listed below.

□ changes in nail texture □ hair loss □ itching □ skin lesions / ulcers
□ changes in skin color □ hives □ tingling □ varicosities
□ hair growth □ history of skin disorders □ rash □ other: _____

Nervous System: □ I **DENY** having any of the symptoms or problems listed below.

□ dizziness □ limb weakness □ numbness □ slurred speech □ tremor □ other: ____
□ facial weakness □ loss of consciousness □ seizure/convulsions □ stress □ unsteadiness of gait
□ headache □ loss of memory □ sleep disturbance □ strokes □ loss of balance

Psychologic: □ I **DENY** having any of the symptoms or problems listed below.

□ anxiety □ behavioral change □ depression □ memory loss □ other: _____
□ confusion □ bi-polar disorder □ insomnia □ mood change

Allergy: □ I **DENY** having any of the symptoms or problems listed below.

□ anaphylaxis □ itching □ chronic nasal congestion □ sneezing
□ food intolerance □ acute nasal congestion □ rash □ other: _____

Hematologic: □ I **DENY** having any of the symptoms or problems listed below.

□ anemia □ blood clotting □ bruising easily □ lymph node swelling
□ bleeding □ blood transfusion □ fatigue

PAST HEALTH HISTORY

Previous Care for Same Condition: □ I have not seen a doctor for this condition **OR** Fill in the information BELOW.

Have you seen other doctors for THIS CONDITION? □ Yes □ No. If yes, Who? (Name) _____
Type of Treatment: _____ Was the treatment beneficial in resolving condition? □ Yes □ No
Explain: _____

Previous Chiropractic Care: □ I have not previously seen a Chiropractor **OR** Fill in the information BELOW.

Doctor's Name: _____ Location: _____ Date of Last Visit: ___ / _____ / _____

Current Medication (s): List **ANY / ALL** medications you are **CURRENTLY** taking. Be Specific.

Medication	Dosage	For What Condition?	How long have you been taking this?

Childhood Illness (es): **LIST** all health conditions. **CIRCLE** all **CURRENT** conditions.

□ ADD/HD □ chicken pox □ headaches □ scoliosis
□ eczema □ Crohn's □ hepatitis □ seizure disorder
□ allergies □ depression □ HIV □ sickle cell anemia
□ anemia □ diabetes □ measles □ spina bifida
□ asthma □ ear infections □ mumps □ Lyme Disease
□ bedwetting □ fetal drug exposure □ psoriasis □ cerebral palsy
□ other: _____

Patient Name: _____ DOB: ____ / ____ / _____ Date: _____

Adult Illness(es): **LIST** all health conditions. **CIRCLE** all **CURRENT** conditions.

□ ADD/HD	□ kidney disease	□ hypertension	□ vertigo
□ Alzheimer's	□ neurological condition	□ pneumonia	□ scoliosis
□ anemia	□ diabetes	□ liver disease	□ seizures
□ arthritis	□ heart disease	□ lung disease	□ shingles / chicken pox
□ asthma	□ eczema	□ fibromyalgia	□ Rheumatoid / Inflammatory Arthritis
□ cancer	□ emphysema	□ lupus erythema	□ Gout
□ Crohn's / colitis	□ CVS (stroke)	□ multiple sclerosis	□ thyroid problems
□ Lyme Disease	□ collagen / vascular	□ Parkinson's disease	□ pneumonia

Doctor: Are Child / Adult Illnesses listed contributory to the CURRENT Condition? □ Yes □ No

Surgery (ies): **LISTall** Surgical Procedures. Write the **DATE** of the Procedure immediately afterward.

□ angioplasty	□ cosmetic	□ hysterectomy	□ pacemaker insertion
□ appendectomy	□ D & C	□ joint reconstruction	□ rotator cuff
□ caesarian section	□ dental surgery	□ joint replacement	□ spinal fusion
□ cardiac	□ gall bladder	□ knee repair	□ tonsillectomy
□ carpal tunnel repair	□ hemorrhoidectomy	□ laminectomy	□ other: _____
□ cardiac bypass	□ hernia repair	□ mastectomy	

Injury (ies): **Mark or Listall** Injuries. Write the **DATE** of the Injury immediately afterward.

□back injury	□ head injury	□ motor vehicle accident	□ other: _____
□ fracture	□ concussion	□ fall (severe)	
□ disability	□ industrial accident	□ joint injury	

Family History: **Mark all** that apply below. List any specific conditions past or present after has / had:

General family	□ alive	□ deceased	□ normally developed	□ no significant disease	□ has / had: _____
Father	□ alive	□ deceased	□ normally developed	□ no significant disease	□ has / had: _____
Mother	□ alive	□ deceased	□ normally developed	□ no significant disease	□ has / had: _____
Paternal grandfather	□ alive	□ deceased	□ normally developed	□ no significant disease	□ has / had: _____
Paternal grandmother	□ alive	□ deceased	□ normally developed	□ no significant disease	□ has / had: _____
Maternal grandfather	□ alive	□ deceased	□ normally developed	□ no significant disease	□ has / had: _____
Maternal grandmother	□ alive	□ deceased	□ normally developed	□ no significant disease	□ has / had: _____
Son (s)	□ alive	□ deceased	□ normally developed	□ no significant disease	□ has / had: _____
Daughter(s)	□ alive	□ deceased	□ normally developed	□ no significant disease	□ has / had: _____
Brother(s)	□ alive	□ deceased	□ normally developed	□ no significant disease	□ has / had: _____
Sister(s)	□ alive	□ deceased	□ normally developed	□ no significant disease	□ has / had: _____

Social History:

Alcohol: □ Never □ Social consumption only □ Frequent

Diet (please mark <u>all</u> that apply) □ High fat □ High Fiber □ High Protein □ High Salt □ High Sugar
□ Low Calorie □ Low Carb □ Low Fiber □ Low Salt □ Low Sugar

Education: (please mark the highest level completed) □ High School □ Assoc/Technical □ College □ Graduate □ Doctorate

Drugs: □ Deny any illegal drug use □ Deny use of IV drugs □ Have not used drugs since _____

Tobacco: □ Deny Tobacco use □ Live with a smoker □ Quit smoking □ Chew
□ Smoke # _____ per □ Day □ Week □ Month

Insurance Information:

Who Is Responsible For Your Bill? YOU and … (mark appropriate box(es)) □ Myself ONLY
□ Spouse □ Worker's Comp □ Auto Insurance □ Medicare □ Medicaid □ Private □ Self- Pay

Personal Health Insurance Carrier: _____ Health ID Card #: _____

Policy Holder's Name: _____ Group #: _____

Policy Holder's Date of Birth: _____ - _____- _____

Patient Name: _____ DOB: ____ / ____ / _____ Date: _____

Dr. Binh Nguyen feels that it is very important we coordinate with your doctor(s) and keep them up to date on your treatment and progress here at our office. Please fill in **any** and **all** information.

Primary Care Physician: _____ Phone #: (____) _____ - _____

Address: _____

Dentist: _____ Phone #: (____) _____ - _____

Address: _____

OB/ GYN: _____ Phone #: (____) _____ - _____

Address: _____

Massage Therapist / Acupuncturist _____ Phone #: (____) _____ - _____

Address: _____

Podiatrist / Optometrist / other Specialist(s) : _____ Phone #: (____) _____ - _____

Address: _____

I give authorization to Cedar Chiropractic & Sports P.C. to release my health care information to the above doctors.

Patient Signature _____

Patient Name: _____ DOB: ____ / ____ / _____ Date: _____

Cedar Chiropractic & Sports P.C.

77 West Main St. Suite 203B – Hopkinton, MA 01748
Phone: (508) 435 – 8182 | Fax: (508) 435 – 8183

Procedure Request and Authorization to Release Medical Records

Date: _____

TO: _____

RE: _____

D/O/B: _____

CLINICAL INFORMATION:

_____

_____

PROCEDURE REQUESTED:

_____ X-Ray with report:

_____ Standing Cervical (AP / Lateral / APOM / Flexion / Extension / Obliques)

_____ Standing Thoracic (AP / Lateral)

_____ Standing Lumbar (AP / Lateral / Flexion / Extension / Obliques)

_____ Other: _____

_____ MRI / CT scan:

_____

_____ Other: _____

Please send copies of my medical records including but not limited to diagnostic reports to Cedar Chiropractic & Sports P.C.

Patient's Signature: _____

Witness: _____

Patient Name: _____ DOB: ____ / ____ / _____ Date: _____

Cedar Chiropractic & Sports 77 West Main Street, Suite 203B ● Hopkinton, MA 01748 p (508) 435-8182

ASSIGNMENT of BENEFITS / DIRECTION of PAYMENT / FINANCIAL POLICY

1. I hereby authorize and direct Cedar Chiropractic & Sports P.C., and all its agents, to release all protected health and medical information necessary to my claims, as outlined in my *Patient Bill of Rights for Protected Health Information.*
2. I hereby authorize and direct my insurance carrier to pay all benefits, which may be due to me under my policy, directly to Cedar Chiropractic & Sports P.C.
3. I hereby give a lien to Cedar Chiropractic & Sports P.C. on any settlement, claim, judgment, or verdict as a result of said accident, and authorize and direct my insurance carrier or attorney to pay directly to Cedar Chiropractic & Sports P.C. such sums as may be due and owed to Cedar Chiropractic & Sports P.C. for services rendered to me, and to withhold such sums from any Personal Injury Protection, Med-Pay, or 3rd Party payments and/or any settlement, claim, judgment, or verdict as may be necessary to protect Cedar Chiropractic & Sports P.C. adequately.
4. I hereby authorize Cedar Chiropractic & Sports P.C. my permission to have on file a copy of my credit card. In the event that they will need to utilize this card, I understand they will notify me via phone or mail, that this transaction(s) occurred to settle any/all unpaid patient balances.
5. Effective January 1, 2009, patients will now be responsible for any non-covered chiropractic services that are performed during their visits. Please check your insurance company's plans as they vary significantly. You have the right to request a sample of out of pocket fees.
6. **All co-payments are due at the time of service,** and if I choose to discontinue care, I am still responsible for any and all unpaid balances. I fully understand that I am directly and fully responsible to Cedar Chiropractic & Sports P.C. for all medical bills incurred for services rendered to me, and that this agreement is made solely for the additional protection, and in consideration, of the risk Cedar Chiropractic & Sports P.C. takes in waiting for payment.

APPOINTMENT POLICY

I understand there is a no show / no call policy. **I will be billed and be responsible for the $45.00 fee.**

BILL OF RIGHTS ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to supply you with a copy of our ***Patient Bill of Rights for Protected Health Information***. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

CONSENT AGREEMENTS (for protected health information (PHI)

By signing, you grant authorization to Cedar Chiropractic & Sports P.C., and all its licensed physicians, to perform diagnostic testing and render Chiropractic care and treatment to yourself or said minor (as the parent or authorized legal guardian); you agree to and give consent to operate under those protocols as outlined. WE RESERVE THE RIGHT TO: change our privacy practices and you have the right to request that we do not disclose your health information to specific individuals, companies or organizations. You may also revoke your consent at any time, however this must be done in writing. By signing this consent, you authorize us to use telephone, text, mail or e-mail, as remainder for appointments. You may also revoke this authorization in writing.

WE ask that you sign this form as acknowledgement that our: AOB/DOP, FINANCIAL, APPOINTMENT POLICIES, CONSENT AGREEMENT AND BILL OF RIGHTS ACKNOWLEDGEMENT, were explained to you, that you understand it, and you accept full responsibility.

I, _____, HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS

DATED _____/_____/ _____.

WITNESS: _____

Patient Name: _____ DOB: ____ / ____ / _____ Date: _____

Cedar Chiropractic & Sports P.C.

77 West Main St. Suite 203B – Hopkinton, MA 01748
Phone: (508) 435 – 8182 | Fax: (508) 435 – 8183

PATIENT BILL of RIGHTS for PROTECTED HEALTH INFORMATION (PHI)

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

III. A. Uses and Disclosures

Here are some examples of how we might have to use or disclose your health care information:

Your chiropractor or a staff member may have to disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.

Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.

Your chiropractor and members of the staff may need to use our health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently run our practice.

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you are not home to receive an appointment reminder, a message will be left on your answering machine. If you prefer, a text will be sent to your phone as an alternative.

You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

B. Our Privacy Pledge

We have an always will respect your privacy. Other than the uses and disclosures we described above, **we will not sell or provide any of your health information to any outside marketing organization**.

C.Permitted uses and disclosures without your consent or authorization

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

We are permitted to use or disclose our health information if we are providing health care services to you based on the orders of another health care provider.

We are permitted to use or disclose your health information if we provide health care services to you as an inmate.

We are permitted to use or disclose your health information if we provide health care services to you in an emergency.

We are permitted to use or disclose your health information if we are required by law to treat you and we are unable to obtain your consent after attempting to do so.

We are permitted to use or disclose your health information if there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

Other than the circumstances described in the preceding five examples and under the ***Uses and Disclosures*** section above, any other use or disclosure of your health information will only be made with your written authorization.

D.Your right to revoke your authorization

You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

If we have already released your health information before we receive your request to revoke your authorization.

If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

If you wish to revoke your authorization please write to us at:

Cedar Chiropractic & Sports P.C.
77 West Main St. Suite 203B
Hopkinton, MA 01748

Patient Name: _____ DOB: ____ / ____ / _____ Date: _____

E. Your right to limit uses or disclosures

If there are health care providers, hospitals, employers, insurers or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

F. Your right to receive confidential communication regarding your health information

We normally provide information about your health to you in person at the time you receive chiropractic services from us. We may also mail you information regarding our health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home or, if you would like the information in a different form. To help us respond to your needs, please make any request in writing.

G. Your right to inspect and copy your health information

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to inspect and/or copy your health information to be in writing.

H. Your right to amend your health information

You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

I. Your right to receive an accounting of the disclosures we have made of your records

You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except those disclosures:

□ required for your treatment, to obtain payment for your services, or to run our practice.

□ to individuals involved with your care.

□ for national security or intelligence purposes.

□ made to correctional officers or law enforcement officers.

□ that were made prior to the effective date of the HIPAA privacy law, April 1, 2003.

We will provide the first accounting within any 12-month period without charge. There is a fee for any additional requests during the next 12 months. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

J. Our duties

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms the change will pally for all of your health information in our files.

K. Re-disclosure

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer by protected by the federal privacy roles.

L. Your right to complain

You may complain to us or to the Secretary for Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be addressed to:

Dept. of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201
Tel: (877) 696-6775

Patient Name: _____ DOB: ____ / ____ / _____ Date: _____

Cedar Chiropractic & Sports PC Financial Policy

We strive to provide the highest quality health care,all the while maintainingaffordability for you,the patient. We understand that even with insurance, mostpatients will experience at least some out of pocket expense.

Participating Insurances

Our office will accept your insurance on assignmentand do participate as preferredproviders for many insurance plans. However, it must be fully understood that yourinsurance policy is a contract betweenyouand your insurance company. Our officewill not enter into a dispute with your insurance company over policy limitations or insurance policy issue. This is your responsibility and obligation.All charges incurred are yourresponsibility.If you have a question or concern with your reimbursement, you willneed to contact your employer or insurance company. Our office will file your claimsfor you and assist you in every way possible to ensure benefit recovery.We cannotbe certain if your insurance covers chiropractic care, although most policies doprovide coverage. Theamount they pay varies from one policy to another. We willcall to verify benefits on your insurance; however, the benefits quoted to us by yourinsurance company are not a guarantee of payment.It is our policy and agreed thatany services rendered are charged to you directly and you are responsible forpayment of any non-covered services, deductibles or co-pays.

Non-Participating Insurances

WewillgladlybillyourInsuranceforyou,andwillcalltodetermineyourchiropracticbenefits.Paymentisdueatthetimeofserviceforalldeductibles,co-pays, and non-covered therapies unless arrangements are with the office staff.

Patients without Insurance

Werequestthat100%oftheexaminationandtreatmentbepaid at the timeofthevisit,unlessotherarrangementshavebeenmade. ToqualifyforourTimeofServiceReductioninfeesyoumust pay on the day the service was performed. Wearehappytoacceptcash,check,MasterCard,Visa,DiscoverorAmericanExpress.No insurance will be billed.

Medicare

Our office accepts assignment from Medicare. Reimbursement is sent directly to ouroffice in payment for chiropractic services that Medicare will cover. Medicare willONLYcover manipulation of the spine. Medicare pays 80%of the allowable fee oncethe deductible has been met. You are required to paythe deductible and the remaining fees for services Medicare does not reimburse.These non-coveredservices include, but are not limited to, x-rays,examinations, therapies, orthotics,supports, and/or nutritional supplements.Medicare patients are fully responsible forcharges of non-covered services.Secondary insurance may or may not pay forthese non-covered services. Ouroffice completes and files the forms for Medicare atno charge.

Secondary Insurance

Please inform us of any secondary insurance you may have. We will file and collectfrom your secondary insurance for services covered by the secondary payer.

Flex Plans/Medical Savings Accounts

Please inform us if you have a medical savings account, or a'flex spending plan'.We will be happy to provide you with a statement of your chargesfor reimbursement.

Health Saving Accounts(HSA)/High Deductible Health Plan

Patient Name: _____ DOB: ____ / ____ / _____ Date: _____

PleaseinformusifyouhaveanH.S.A.AsChiropracticisaqualifiedexpenseandthis canbe paid through your H.S.A. and billed to your high deductible health plan.Please read the following office policy regarding assignments:

1. At the beginning of your treatment in our office we will verify your policybenefit. However, phone or fax verification of coverage is never a guarantee ofpayment.

2. Returned checks and balances over 90 days may be subject to additionalcollection fees and interest charges of 4% per month. Charges may also be made for missedappointments and those canceled without 24 hours notice.

3. Your insurance will be filed as a courtesy to you. We file insurance claims ona weekly basis.

4. You will be responsible for your full deductible and co-payment or co-insurance. Payment is due when services are rendered. If your insurancecompany does not pay something that was anticipated, you will be responsiblefor the amount as soon as we/you are of aware of the denial.

5. If you pay the full amount for services rendered each visit, you may qualifyingfor our Time of Service (TOS) discount. You may then submit the bill to yourinsurance company for reimbursement.

6. If your insurance company has not paid a claim within sixty (60) days ofsubmission, you agree to take an active part in the resolution of your claim. Ifyour insurance company has not paid within ninety (90) days of submission, youare responsible for payment of any outstanding balance.

7. Our fees are considered usual and customary by most insurance companies,and therefore are covered up to the maximum allowance determined by eachinsurance company. This statement does not apply to companies who reimbursebased on anarbitrary schedule of fees bearing no relationship to the current
Standard of care in this area.

Personal Injury (PI)or Automobile Accidents

Please present your auto insurance card, your health insurance card, and inform usif you have retained an attorney. If you need an attorney we will refer you to an attorney.

There are four options available to the PI patient:

1.Pay cash for your care and we will submit reports whenever necessary.
2.We will bill and accept assignment from the portion of your autoinsurance.
3.We will accept a Letter of Protection or Doctor's Lien from an attorney.
4. Account balances 90 days past the release date of treatment will incur a 4%monthly charge.
4.We will bill your standard health insurance plan if your auto insurance policy medical coverage is exhausted and you will be responsiblefor all co-pays and deductibles as they are incurred.

Although you are ultimately responsible for your bill, we will wait for settlement ofyour claim for up to 6(six)months after your care is completed. Once the claim issettled or if you suspend or terminate care, any fees for services are dueimmediately.

Patient Name: _____ DOB: ____ / ____ / _____ Date: _____

Ihavereadandunderstandthisfinancialpolicy.IrealizethatIamresponsibleforallchargesincurredbymeat Cedar Chiropractic & Sports PC.

WE ask that you sign this form as acknowledgement of our financial policy agreement:**Cedar Chiropractic & Sports PC Financial Policy**, were explained to you, that you understand it, and you accept full responsibility.

I, _____, HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS

DATED _____/_____/ _____.

WITNESS: _____

INFORMED CONSENT

I have received the information about my condition and proposed chiropractic treatment program as well as alternative courses of care, the benefits, the risks, and the side effects of the treatment and the consequences of not having the proposed treatment. I understand and am informed that, as in all health care, in the practice of chiropractic there are some rare risks to treatment, including but not limited to muscle soreness, muscle aches, muscle bruising, muscle strains and sprains, fractures, dislocations, disc injuries, and strokes. I do not expect the healthcare provider to be able to anticipate or explain all risks and complications. I wish to rely on the provider to exercise judgment during the course of the treatments which they feel at the time, based upon the facts then known, is in my best interests. My chiropractor has responded to all of my requests for information about the proposed treatment. I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content. By signing below, I consent to chiropractic treatment. I also consent that I have authority and responsibility to authorize treatment for my child if such condition is applicable.

_____ _____

Patient's Printed Name **Patient's Signature Date**

_____ _____

Parent's Name **Parent's Signature Date**

_____ _____

Doctor's Name **Doctor's Signature Date**

Patient Name: _____ DOB: ____ / ____ / _____ Date: _____

Credit Card on File Agreement

We have implemented a policy which enables you to maintain your credit card information securely on file with Cedar Chiropractic & Sports, PC. **In providing us with your credit card information, you are giving Cedar Chiropractic & Sports, PC permission to automatically charge your credit card on file for your (or any other patient(s) you have listed on this form) co-pay/s, outstanding balance/s, service/s, missed appointment/s without cancellation and /or product/s)**

Co-pays: Co-pays are due at time of the office visit.

Outstanding Balance: If your insurance provider has paid their portion of your bill (or any other patient(s) you have listed on this form) and there is still an outstanding balance owned, Cedar Chiropractic &Sports , PC will notify you via phone and/or mail. If by the final billing notice from Cedar Chiropractic & Sports, PC, we do not receive a response from you or your payment in full, at that time, any balance owed will be charged to your credit card. A copy of the charge will be mailed to you. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

Service and Products: missed appointment/s without cancellation and product fee are due at time of office visit.

This card will only be authorized for the use of the credit card holder or any person(s) listed below by the credit card holder. **This agreement will expire on the expiration date listed below.** The card holder may also revoke this consent at any time in writing.

1. **Visa**
2. **MasterCard**
3. **Discover**
4. **American Express**

Credit Card Holder's Name:_____ DOB:_____/_____/_____
(Plesee Print Name in Full)

Credit Card Number :_____

Expiration Date: _____

Please fill out information below for any other person/s you authorize this credit card for:

Patient Full Name: _____ DOB: _____/_____/_____

Patient Full Name: _____ DOB: _____/_____/_____

Patient Full Name: _____ DOB: _____/_____/_____

Credit Card Holder's Address: _____

Credit Card Holder's CVV number: _____

Credit Card Holder's Signature : _____ Date: _____