



CUPP CHIROPRACTIC CLINIC

DR. REE ANN CUPP



Acct # _____

PEDIATRIC PATIENT INFORMATION

Child's Name: _____

Social Security Number: _____ Male Female

Birthdate: _____ Age: _____

Mother's Name: _____ Phone Number _____

Father's Name: _____ Phone Number _____

Address: _____

City: _____ State: _____ Zip: _____

Type of Birth: Vaginal _____ Forceps _____ Breech _____ Cesarean _____

Birth Weight: _____ lbs. _____ oz. Present Weight: _____

Problems during Pregnancy or Delivery: _____

Congenital Anomalies / Defects: _____

Hours of Sleep per Night: _____ Quality of Sleep: _____

Date of Last Visit to M.D. _____ Purpose: _____

Immunization History: _____

Purpose of this visit: _____

Has Your Child Been Treated on an Emergency Basis? Yes No

Explain: _____

Other: _____

Please See Other Side →



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Has Your Child Ever Suffered From?

- | | | |
|----------------------------------------------|----------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Neuritis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Orthopedic Problems |
| <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting | <input type="checkbox"/> Poor Appetite |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> "Growing Pains" | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Backaches | <input type="checkbox"/> Headaches | <input type="checkbox"/> Rubella |
| <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Ruptures/Hernias |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Hypertension " | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Sugar Concentration |
| <input type="checkbox"/> Chronic Earaches | <input type="checkbox"/> Leg Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Colds / Flu | <input type="checkbox"/> Measles | <input type="checkbox"/> Walking Problem |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Mumps | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Muscle Jerking | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neck Problems | |

Present History: _____

Surgery: _____

Medications: _____

Accidents: _____

Family History: _____

I Hereby Acknowledge This Clinic and its Doctor(s) to Administer Care as they Deem Necessary to my Child.

Parent's Name: _____

Parent's Signature: _____ Date: _____

Please See Other Side →



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CONSENT TO TREAT A MINOR CHILD

I hereby authorize Dr. Ree Ann Cupp, D.C. and whomever she may designate as her assistants to administer treatment as she so deems necessary to my _____, _____.

Dated at Metairie, Louisiana this _____ day of _____ 20_____.

Signed _____

Address _____

Witness _____

Address _____

Signature _____



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Patient Disclosures and Authorizations

Please read the following information and initial in the appropriate sections.

Insurance Coverage

Welcome to Cupp Chiropractic Clinic. We will be more than happy to submit all insurance forms for you and help you recover the most from your benefits. Your insurance policy is an agreement between you and your insurer, not between your insurer and this clinic. Like all types of care, coverage for chiropractic services varies from insurer to insurer and plan to plan. Most insurance policies require the policy holder to pay co-insurance, co-payment and/or a deductible. If we are a participating provider for your specific insurance company, then we will abide by our contract fees, which include your co pay and/or deductible responsibility. Our clinic will call your insurer to verify your benefits; however, we are not responsible for your insurer's final payment and benefit determinations.

I understand and agree that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any and all fees for professional services rendered to me will be immediately due and payable.

Patient Initials _____

Missed and/or Late Appointments

It is the policy of Cupp Chiropractic Clinic to assess a **\$15.00 missed visit fee to patients who cancel appointments with less than a 24-hour notice.** One missed visit will not result in the assessment of a fee, but you will be charged for any additional missed visits. It is also the policy of Cupp Chiropractic Clinic to **reschedule any appointment that a patient is more than 15 minutes late to.** This clinic provides care for many individuals and late or missed visits result in time lost that could have been used to provide care for others in need.

Patient Initials _____

Consent for Use or Disclosure of Health Information

Privacy Pledge

We are very concerned with protecting your privacy. While the law prohibits our office from selling your protected health care information and requires us give you this disclosure, please understand that we have and always will, respect the privacy of your health care information. Our office will make you aware of any breach of your protected health care information.

Medical Release

There are several circumstances in which we may have to use or disclose your health care information:

- ~ To another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- ~ To another party if they are potentially responsible for the payment of your services.
- ~ To family and/or friends who were involved in providing care or payment for care in the event of the patient's death. This HIPAA Protection is void 50 years after a patient's death.
- ~ To an insurance company, adjuster or attorney in order to process any claims for reimbursement of charges incurred by me.
- ~ Within our practice for quality control or other operational services such as sending the following products to you: Appointment reminders, Birthday cards, Newsletters, Thank you cards, and any and all correspondence with Dr. Cupp.
- ~ To the Chiropractic Association of Louisiana if we need the CAL's assistance to receive reimbursement for your services or because the party responsible for reimbursing your services has improperly processed your claim. By signing this form you are giving CAL authorization to re-disclose your information to the party responsible for the payment of your services, the CAL's legal counsel and state or federal agencies that may be asked to intercede on your behalf.

Your Right to Limit Uses or Disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. It will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care. We are not required to agree to your restrictions; however, if we agree with your restrictions, the restriction is binding.

Your Right to Revoke Your Authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. 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 care information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by the person who receives the information and may no longer be protected by the federal privacy rules.

You may inspect or copy the information that we disclose at any time (§ 164.524).

I hereby authorize you to release any of my health information in the manner described above.

Patient Initials _____

Assignment, Lien & Authorization for Direct Payments by my Payers to Cupp Chiropractic Clinic

Assignment and Lien Terms

I hereby assign to Cupp Chiropractic Clinic to the extent permitted by law, but only to the extent of my Charges, all of my claims to, rights to, and interests in, Proceeds, whether resolved or unresolved, including without limit ownership rights, which I may have now or in the future relating directly or indirectly to my Charges, condition, or causes of my condition (“Claims to Proceeds”), including without limit any and all causes of action, receivables, payment intangibles, and remedies that I might have against or with respect to any Payer now or in the future, and the right to prosecute, seek, settle, or otherwise resolve such Claims to Proceeds either in my name or in the Cupp Chiropractic’s name. I agree that this assignment shall be effective as of the date and time the initial cause of my condition occurred. I further intend for this Assignment & Lien to create a security interest under the applicable Uniform Commercial Code. Accordingly, I hereby grant to Cupp Chiropractic Clinic a primary, non-contingent security interest in all of my Claims to Proceeds to the extent permitted by law for the purpose of securing payment of my Charges, the attachment and perfection of which shall relate back to, and be effective as of, the date and time that the initial cause of my condition occurred. I further authorize the Cupp Chiropractic to file the form(s) normally filed with the secretary of state or other governmental agency relating to such security interests, and to make such filings in all relevant jurisdictions as Cupp Chiropractic sees fit in its sole discretion. I agree that once payment in-full has been made towards all outstanding Charges to the full extent permitted by law or contract and also as defined by my agreement with Cupp Chiropractic, such security interest shall be removed or terminated solely upon my written request sent through the U.S. Postal Service Certified Mail. Consistent with these terms, I hereby direct any and all Payers, to pay the Proceeds directly to, immediately to, and exclusively in the name of, Cupp Chiropractic Clinic to the full extent of my Charges. To the extent that any law, including without limit a lien statute, purports to limit, reduce, or modify the distribution of Proceeds in any manner inconsistent with this Assignment & Lien including without limit through the reservation of a portion of the Proceeds exclusively to me, I hereby waive such limits, reductions, or modifications. Such waiver shall not adversely affect or prejudice any rights which Cupp Chiropractic may have and elect to exercise under said law.

Specific Direction to Any Attorney I Retain, Such as in Accident Cases

In the event that I retain one or more attorneys who receive(s) Proceeds from one or more Payers, I hereby direct (and Cupp Chiropractic hereby requests) each attorney to provide immediate notice to Cupp Chiropractic regarding such Proceeds, to promptly pay Cupp Chiropractic in-full out of such Proceeds, and to provide a full accounting of such Proceeds. I agree that the purpose of such Proceeds shall be primarily to pay my Charges. If I have a dispute regarding the Charges, any remedies I may have shall not include instructing my attorney to withhold or delay payment of Proceeds to Cupp Chiropractic. I further agree to and hereby irrevocably waive any present or future right I may have, whether arising under a “Common Fund Doctrine” or other legal basis, to require Cupp Chiropractic to absorb the costs associated with, or otherwise assume responsibility for, any portion of my attorney’s fees and costs, or other expenses of obtaining Proceeds.

Disclosure Directives

I hereby direct each and every Payer to immediately release to Cupp Chiropractic any Pertinent Information relating to (a) any coverage I may have and (b) any Proceeds Determination by the Payer relating to Cupp Chiropractic's Charges. "Pertinent Information" shall include without limit the amount of total coverage available and remaining, as well as the amount of any outstanding claims which the Payer has received from any claimant relating to my condition. "Pertinent Information" shall also include without limit copies of all documents, records, and other information (a) relied upon by the Payer in making a Proceeds Determination, or (b) was submitted, considered, or generated in the course of making a Proceeds Determination without regard to whether such document, record, or other information was relied upon in making the Proceeds Determination. "Proceeds Determination" shall include without limit any determination by the Payer to pay, deny, or delay payment of any Proceeds relating to Cupp Chiropractic's Charges, as well as a decision to refer the Charges to an independent review or audit, utilization review, or independent medical exam. I further authorize and direct Cupp Chiropractic to release any information relating any services rendered to or for me by Cupp Chiropractic to all Payers, including without limit a copy of my Charges and a copy of this Assignment & Lien, unless otherwise agreed to in writing.

I have read, understood, and agree to the terms of this Assignment & Lien.

Patient Initials _____

Payment for Services

It is the policy of Cupp Chiropractic Clinic to have our patients **make any and all payments due on their account upon arrival** unless otherwise agreed upon.

Patient Initials _____

I understand that all health services rendered to me and charged to me are my personal financial responsibility.

I understand and agree to the conditions of this policy.

I have read and received a copy of this agreement. **Patient Initials** _____

Patient Name Printed

Dr. Ree Ann Capp D.C.
Authorized Provider Representative

Patient Signature

Kristina Mercier or Robin Galjenboom
Personal Representative Signature

Patient Account Number

Date