Scott Chiropractic Center Financial Policy & Informed Consent

Welcome to Scott Chiropractic Center, thank you for choosing us as your Chiropractic office!
Our recommendations are based on a desire to see you get well and stay well; we will suggest **only** the chiropractic care we think you need.

Patients Without Insurance (Private Pay): We request that 100% of the first visit be paid at the time of the visit. **Patients who pay in full at the time of service are eligible for our TIME OF SERVICE DISCOUNT.**

Group or Individual Insurance: Your insurance is a contract between you and your insurance company, our office is not a part of that contract. We will call to verify benefits on your insurance; however, **the benefits quoted to us by your insurance company are not a guarantee of payment.** It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles or co-pays at the time of your visit.

Medicare: We accept assignment from Medicare. Chiropractic coverage for Medicare is ONLY manual manipulation of the spine for active care, all other services are considered NON-COVERED; including maintenance care, exams, therapy, supports, and/or nutritional supplements. Medicare pays 80% of the allowable fee **after the deductible has been met for active care.** You are required to pay the deductible and the remaining 20% including Non-Covered services.

Personal Injury or Auto Accidents: Please present your auto insurance card, your health insurance card, and tell us if you have retained an attorney. Ask to see our **Personal Injury Policy.**

Missed Appointments: It is the policy of **Scott Chiropractic Center** to assess a **$25. missed appointment fee** to patients who cancel appointments with less than 12-hour notice. One missed visit will not result in the assessment of a fee, but you will be charged for any additional missed visits.

Payment Options: Cash Checks Visa MasterCard Discover Health Savings Account **Any balances over 30 days will be assessed a $5.00 monthly late fee if not paid by the next billing statement.**

I have read and understand the financial policy of Scott Chiropractic Center. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctors at Scott Chiropractic Center that fees will be due and payable immediately. Would you like a copy of this form? Yes No

Patient/Guardian Signature _____

Informed Consent: A patient, in coming to the chiropractor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at **Scott Chiropractic Center, LLC**, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Communications: In the event that we would need to communicate your healthcare information, to whom may we do so? Spouse _____ Children _____ Others: _____ No one: ____ May we leave messages regarding your personal healthcare information on any answering device, i.e. home answering machines or voicemails? Y N

Acknowledgement: I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Consent to Evaluate and Treat a Minor: I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Patient/Guardian Signature: _____ Date _____

Scott Chiropractic Center, LLC * Timothy D. Scott, D.C. * Jennifer L. Rogers, D.C.

*1005 Marion Rd. * Bucyrus, OH 44820 * 419 562-6565 * www.scottchiro4health.com*

CONFIDENTIAL PATIENT INFORMATION (please print)

Last Name: _____ First Name: _____ Initial: _____ Nickname: _____

Address: _____City:_____ State: _____ Zip: _____

Preferred Phone # _____ Secondary Phone # _____

Birthdate: _____ Age: _____ Male Female SS#: _____

Marital Status: S M W D Spouse's Name: _____ Spouse's Birthdate _____

Number of children: _____ Names and Ages of Children: _____

Your Employer: _____ How long? _____Occupation: _____

Spouse's Employer _____Family Physician: _____ Last Visit: _____

May we have your permission to update your medical doctor regarding your care at our office? Y N

May we subscribe you to our monthly practice eNewsletter? Y N E-Mail: _____

Emergency Contact Name & Phone No._____

How did you hear about us? Family Friend Health Fair Internet Phone Book Sign Other _____

Whom shall we thank for referring you to our office? _____

Primary Insurance: _____ Insured's Name: _____ Birthdate: _____

Insured's SS#: _____ **Please allow us to copy your Photo ID and Insurance Card**

Have you ever been under Chiropractic Care? Y N If so, who and when? _____

Have you had any SPINAL X-Rays /MRI's /CT's taken in the past year? Y N If so, where? _____

What surgeries have you had? (Include date) _____

What serious illness have you had? (Include date)_____

What medications/drugs are you taking: (circle those that apply) Pain Killers Muscle Relaxers Insulin Cholesterol Meds

Blood Pressure Meds Birth Control Other: _____

Are you seeking? Wellness Care - Optimum health & wellness Relief Care - Feel better for least amount of time & money

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at the clinic's request, and convey directly to **Scott Chiropractic Center, LLC** all medical benefits and/or insurance reimbursements, if any, otherwise payable to me for services rendered from such doctor and clinic. **I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments.** I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer, and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law, any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Patient/Guardian Signature: _____ Date _____

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CASE HISTORY

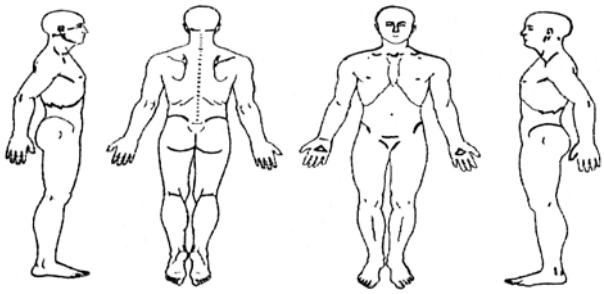
Name _____ Date _____

Are your present symptoms or condition related to, or the result of an auto accident, work-related injury or other personal injury?
YES NO

1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

Condition / Problem	Severity (Minimal 0 1 2 3 4 5 6 7 8 9 10 Severe)	Frequency (during week)		
a. _____	0 1 2 3 4 5 6 7 8 9 10	Occasional	Frequent	Constant
b. _____	0 1 2 3 4 5 6 7 8 9 10	Occasional	Frequent	Constant
c. _____	0 1 2 3 4 5 6 7 8 9 10	Occasional	Frequent	Constant
d. _____	0 1 2 3 4 5 6 7 8 9 10	Occasional	Frequent	Constant

(Please mark the figures where you experience pain.)



2. Symptoms are <u>worse</u> in the: (circle what applies)

-Morning -Increase during the day

-Afternoon -Same all day

-Night -Decrease during the day

3. Symptom (a.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
4. Symptom (b.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
5. Symptom (c.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
6. Symptom (d) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
7. When did your symptoms begin (onset date)? _____ How did your symptoms begin? _____
   _____
8. Have you experienced these before? Y N Describe: _____
9. Do your symptoms radiate? Y N Describe: _____
10. Has your condition? Improved Gotten Worse Stayed the same since it began
11. Which of the following has been affected by your condition?
    Personal Care - Sitting - Standing – Walking – Bending – Lifting – Sleeping – Driving – Work – Other _____
    Details: _____
12. Is there anything you can do to relieve the problems? Y N Describe: _____
    If No, what have you tried that has not helped? _____
13. Have you been treated for this before? Y N How long ago? _____
14. What treatment did you receive? _____
15. Results of previous treatment? Good Poor Comments _____
16. List any other major conditions you have had, other than those mentioned above: _____
17. Complicating factors: Severity Past Episodes Duration Age DJD Obesity/Overweight Diabetes Deconditioning
18. *** Do you have a pacemaker? Y N Have you ever had any Shoulder, Hip, or Knee Replacements? Y N**
19. WOMEN ONLY: Are you pregnant or is there any possibility that you may be pregnant? Y N Uncertain

I certify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature _____ Staff Initials_____

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