PURPOSE CHIROPRACTIC

2850 National Drive Suite 105, Onalaska, WI, 54650
(608) 519-5767 www.purposechiro.com

Welcome to Purpose Chiropractic – wellness with a purpose!

About the office

Dr. Marty Lorentz

Phone: 608-519-5767

Fax: 608-519-5768

Website: www.purposechiro.com

Location: 2850 National Drive Suite 105, Onalaska, WI 54650

Hours:	Monday	8-11 & 3-6pm
	Tuesday	8-11 & 3-6pm
	Thursday	8-11 & 3-6pm
	Friday	7:30-10 & 1-3:30pm

Financial Information

If you have health insurance or another reimbursement account, we will provide you with everything you need to get credit/reimbursement for your care. We will give you the most accurate information regarding what your insurance may pay. This arrangement will allow us to provide the best care at a great value. Our goal is to make everything as simple and straightforward as possible so you are not surprised by any unexpected costs. Our fees are posted below.

New Patient Exam:	$70
Adjustment:	$53-$70
Reevaluation Exam:	$40
Cervical & Lumbar X-rays:	$150
Scan only:	$20

For cash patients that pay the day of service, a discount is applied to the fees above. We accept cash, check MasterCard, Visa and Discover. If you have any questions, please feel free to ask.

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Non Insurance Payment Options

For patients with no insurance coverage or those that have reached maintenance care.

Option 1 – Day of Service

Pay the day of service and receive a 30% savings.

Regularly $53.00 you pay $38.00

Option 2 – Prepayment Option

Purchase in increments of 6 adjustments (6, 12, 18, 24…) for $33 each. A $5 savings each adjustment. Almost a 40% savings. 6 visits at $33 each = $198

Option 3 – Family Plan

Mom and/or Dad can take advantage of option 1 or 2, and the 2nd through 4th family member may pay the "day of service" option for only $25.00. (At least one parent must be an active patient within the last 3 months.)

Cash, check or credit card accepted.

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We send out a monthly billing statement, and we appreciate payment within 15 days of receipt of the statement. We also ask that any balance that you may acquire stay below $200. If you have special circumstances or have questions regarding these options, please call and speak to Leslie. We would be happy to help in any way we can. 608-519-5767

We thank you for putting your trust in us, and letting us be a part of your health care!

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Parent(s) Name (First, MI, Last) _____

Childs Name (First, MI, Last) _____

Address _____ City, State, Zip _____

Home Phone _____Cell/Work _____

E-mail address _____

Date of Birth _____

Marital Status ◯Single ◯Married ◯Separated ◯Divorced ◯Widowed

Spouse's Name _____

Financially Responsible Party _____

I would like to receive updates, newsletters, product discounts and other marketing information via mail or email. Initials _____ (This is helpful if we close early or are closed on a normally open day.)

Would you like your child's care at Purpose Chiropractic filed to insurance? ◯Yes ◯No

Policy Holders Date of Birth _____

We are in network with many insurance companies. We will make a copy of the insurance card and let you know what they cover in our office. If the insurance company pays the policy holder directly, we request you pay for the service at the time of the visit. Please let us know if you have any questions.

Child History

Childs Name _____ Today's date: _____

Sex: M F Date of Birth _____ Age: _____

Reason for today's visit:_____

Please mark the box that best answers the question.

Y	N	Questions/Comments
		Does your child complain of pain or discomfort? If yes, when did this occur? Was onset Sudden □ or Gradual □ Is problem Constant □ or Intermittent □
		Has your child ever had this before?
		Has your child previously been treated for this problem? By whom?
		Has this child had previous chiropractic care?

Y	N	Questions/Comments
		Are there any smokers in the child's home?
		Has your child had any upper respiratory infections?
		Has your child had asthma?
		Is your child allergic to anything?
		Does your child ever complain of back or neck pain?
		Does your child ever complain of pain in the arms or legs?
		Does your child ever complain of headaches?
		Does your child ever complain of earaches? At what age did first occur?
		How frequently does your child have earaches?
		Do your child's earaches usually tend to occur in the same ear? R L Both
		Has your child had any other illnesses? Please list each illness and its approximate date.
		Is your child presently receiving any medications?
		Has your child ever been to a hospital or emergency room for evaluation or treatment?
		Has your child been vaccinated?
		Do you have any other concerns about your child's health?

Trauma

Y	N	Questions/Comments
		Has your child had any recent falls or trauma? Describe the trauma and the date it occurred.
		Has your child ever fallen down the stairs or fallen from any height?
		Has your child ever been in a motor vehicle collision or near miss?

		Has your child ever had a bone fracture or joint dislocation?
		Has your child had any other trauma or injuries?
		Does your child ever bang his/her head repeatedly against a wall, bed or other object?

Nutrition

Y	N	Questions/Comments
		Do you have any concerns about your child's diet?
		Does your child have any food allergies?
		Does your child have any persistent or intermittently occurring skin rashes?
		Does your child take vitamin supplements?
		Does your child eliminate stools each day?

For how many months was your child breast-fed? _____
What does your child usually eat for breakfast? _____
What does your child usually eat for lunch? _____
What does your child usually eat for dinner? _____
What does your child usually eat for snacks? _____
How much cow's milk does your child drink each day? _____
What is your child's favorite food? _____
What type of fast foods does your child like to eat? _____

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal; to remove nerve interference and allow the body to self-heal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another healthcare provider.

All questions regarding the doctor's objectives pertaining to care in this office have been answered to my complete satisfaction.

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____, have read and fully understand the Terms of Acceptance and hereby grant permission for my child to be examined and receive chiropractic care if deemed applicable.

_____ _____

(Signature) (Date)

PURPOSE CHIROPRACTIC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I (parent name), _____, acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Purpose Chiropractic, which describes the Office's policies and procedures regarding the use and disclosure of any of my child's Protected Health Information created, received or maintained by the Office.

Child's Name _____

Signature _____ Date _____

DISCLOSURE OF HEALTH INFORMATION

Please list the name(s) of those whom you authorize us to disclose your child's health information to as it relates to their care in this office.

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

EMERGENCY CONTACT INFORMATION

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

I authorize representatives of Purpose Chiropractic to disclose my child's health information to the above mention person(s). I understand that I may alter this list at any time and that this authorization will remain in effect until I provide written notice of its termination.

Signature _____ Date _____

PURPOSE CHIROPRACTIC NOTICE OF OUR PRIVACY PRACTICES

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your individually identifiable health information.

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (**IIHI**). In conducting our business, we will create records regarding you and your treatment and the services we provide for you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at this time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Purpose Chiropractic LLC

2850 National Drive #105 Onalaska, WI 54650

(608)519-5767

C. WE MAY USE AND DISCLOSURE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. Any of the people who work for our practice – including, but not limited to, our doctors and nurses, or indirectly with any provider we refer you to – may use or disclose your IIHI in order to treat you, or to assist others in your treatment. Additionally, we may need to disclose your IIHI to others who may assist in your care, such as your spouse, children, or parents.

2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment and health status to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members or insurance companies. Also, we may use your IIHI to bill you directly for services and items.

3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities for our practice.

4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you or a family member who answers the phone (or to leave a recorded message) to remind you of an upcoming appointment.

5. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

7. **Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to our office for care. In this example, the babysitter may have access to this child's medical information.

8. **Disclosures Required by Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. In general, we will require that the party that requests your records provide a records-release form, signed by you within the last 3 months.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices

- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identify or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organs and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation in you are an organ donor.

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a research that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research and (iii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the research only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research, and if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your IIHI for worker's compensation and similar programs.