# Patient Information

Name: _____ Date: _____
Address: _____
Cell Number**:** _____ Home Number: _____
Email: _____
Birth Date: _____ Age: _____ Sex: _____
Marital Status: _____ Number of Children: _____
Last Four of Social Security Number: _____
Employer: _____ Occupation: _____
How did you hear about Beach Life Chiropractic: _____

*IN CASE OF EMERGENCY, PLEASE CONTACT*
Name: _____ Relation: _____
Phone Number: _____ Birth Date: _____ Contact's Employer: _____

Current Complaints
How did the symptoms occur? _____
_____ Date symptoms appeared: _____
Have you ever had the same conditions? ◯ Yes ◯ No If yes, when? _____
List of practitioners seen for this injury/condition: _____
Have you been under chiropractic care? ◯ Yes ◯ No
If yes, please describe: _____

Insurance Information
Health Insurance ***(Primary)***
Insurance: _____ Phone Number: _____
Policy Number: _____ Group ID: _____
*(Secondary)*
Insurance: _____ Phone Number: _____
Policy Number: _____ Group ID: _____

Name of the Insured: _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/ treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature: _____ Date: _____
Guardian's Signature: _____ Date: _____

Beach Life Chiropractic

Is there a chance you could be pregnant? ◯ Yes ◯ No
Have you had X-Rays taken? ◯ Yes ◯ No If yes, when and where? _____
What medications do you take? Please list the corresponding medications with the dosage

_____

_____

What vitamins or minerals do you take? _____

| *Have you ever:* | NO | YES | Briefly Explain |
|---|---|---|---|
| Broken any bones? | ◯ | ◯ | _____ |
| Been hospitalized? | ◯ | ◯ | _____ |
| Been in an auto accident? | ◯ | ◯ | _____ |
| Had sprains/strains? | ◯ | ◯ | _____ |
| Been struck unconscious? | ◯ | ◯ | _____ |
| Had Surgery? | ◯ | ◯ | _____ |

*Please list any family health conditions or concerns:* _____

_____

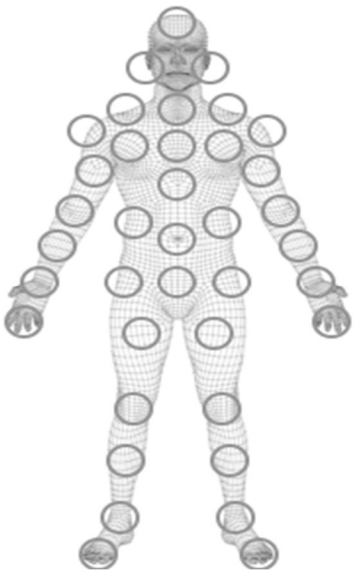
| | NO | YES |
|---|---|---|
| Do you experience pain every day? | ◯ | ◯ |
| Do your daily symptoms interfere with daily life? | ◯ | ◯ |
| Does pain wake you up at night? | ◯ | ◯ |
| Are your symptoms worse at certain times of the day? | ◯ | ◯ |
| Do changes in the weather affect your symptoms? | ◯ | ◯ |
| Do you wear orthotics? | ◯ | ◯ |
| Do you take vitamin supplements? | ◯ | ◯ |

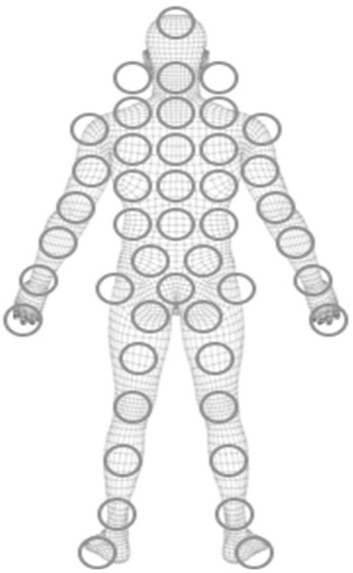
*What activities provoke your symptoms?* _____

_____

| *Habits* | NONE | LITTLE | MODERATE | HEAVY |
|---|---|---|---|---|
| Alcohol | ◯ | ◯ | ◯ | ◯ |
| Coffee | ◯ | ◯ | ◯ | ◯ |
| Tobacco | ◯ | ◯ | ◯ | ◯ |
| Drugs | ◯ | ◯ | ◯ | ◯ |
| Exercise | ◯ | ◯ | ◯ | ◯ |
| Sleep | ◯ | ◯ | ◯ | ◯ |
| Appetite | ◯ | ◯ | ◯ | ◯ |
| Soft Drinks | ◯ | ◯ | ◯ | ◯ |
| Water | ◯ | ◯ | ◯ | ◯ |
| Salty Foods | ◯ | ◯ | ◯ | ◯ |
| Sugary Foods | ◯ | ◯ | ◯ | ◯ |
| Artificial Sweeteners | ◯ | ◯ | ◯ | ◯ |

Beach Life Chiropractic





Please use the following letters to indicate the TYPE and the LOCATION of the symptoms you are currently experiencing.

| | |
|---|---|
| A = Ache | O = Other |
| B = Burning | P=Pins&Needles |
| N = Numbness | S = Stabbing |

*Have you suffered from:*

__ Alcoholism
__ Allergies
__ Anemia
__ Arteriosclerosis
__ Arthritis
__ Back Pain
__ Breast Lump
__ Bronchitis
__ Bruise Easily
__ Cancer
__ Chest Pain/Conditions
__ Cold Extremities
__ Constipation
__ Cramps
__ Depression
__ Diabetes
__ Digestion Problems
__ Ears Ring
__ Excessive Menstruation
__ Eye Pain/Difficulties
__ Fatigue
__ Frequent Urination
__ Headache
__ Hemorrhoids
__ High Blood Pressure
__ Hot Flashes
__ Irregular Heartbeat
__ Irregular Cycle
__ Kidney Infection
__ Kidney Stones
__ Loss of Memory
__ Loss of Balance
__ Loss of Taste
__ Lumps in Breast
__ Neck Pain/Stiffness
__ Nervousness
__ Nosebleeds
__ Pacemaker
__ Polio
__ Poor Posture
__ Prostate Trouble
__ Sciatica
__ Shortness of Breath
__ Sinus Infection
__ Sleep Problems/Insomnia
__ Spinal Curvatures
__ Stroke
__ Stroke
__ Swelling of Ankles
__ Swollen Joints
__ Thyroid Condition
__ Tuberculosis
__ Ulcers
__ Varicose Veins
__ Venereal Disease
__ Dizziness

# BEACH LIFE CHIROPRACTIC PATIENT RIGHTS

The office will strive to ensure that your rights as a patient of this office are preserved. You have a right to a dignified existence, self-determination and communication with and access to persons and services inside and outside this office. You have the right to be free of coercion, discrimination and reprisal from our office in exercising your rights.

This office strives to promote health and healing of patients in a manner and an environment that maintains or enhances each patient's dignity and respect, in full recognition of his or her individuality.

You have the right to be free from verbal, sexual, physical and mental abuse. This office will not knowingly employ any individual who has been found guilty by a court of law of such offenses.

The Compliance Officer and/or Compliance Manager will promptly investigate any alleged abuse of a patient.

You have the right to receive services in this office with reasonable accommodation of individual needs and preferences, except when your health and safety of other persons would be endangered. You have the right to communicate in your own language and receive assistance, as we can provide.

You have the right to be informed about the services offered by this office and the charges for those services. You also have the right to be informed of any changes in the services offered by this office or in the changes to its services.

You have the right to be informed about the care, treatment options and any change that may affect your health and wellbeing.

You have the right to discuss any problem you encounter in this office with the doctor.

You have the right to be fully informed of your condition in a language you can understand.

In the event of:

(1) A significant change in your physical, mental, or psychological status,
(2) A need to alter treatment significantly or,
(3) A decision to transfer or discharge you as a patient of this office,

Problems will be promptly addressed, and corrective action will be taken.

You have the right to be informed about any changes in your care and treatment that may affect your wellbeing. Information contained in your medical records is confidential and will not be disclosed to unauthorized persons without your written consent or the written consent of your legal guardian, except as required or permitted by law or as set forth below.

In some instances this office may choose to release or receive, without any further authorization from you, all or any part of your medical records to or from any person or entity which has or may have a legal or contractual obligation to pay all or a portion of the cost of care provided to you, including, but not limited to, hospital or medical services companies, insurance companies, workers' compensation carriers, Medicare, Medicaid or your employer. If you require a copy of your records, this office may charge you a reasonable fee for such copies.

You have the right to personal privacy, including privacy in accommodation, chiropractic treatment, written and telephone conversations.

You have the right to expect quality chiropractic care at a reasonable cost and that diagnostic testing will only be ordered if the doctor truly feels it is necessary.

You have responsibilities as a patient. You are responsible for providing information about your health, including past illnesses, hospital stays, and use of medicine. You are responsible for asking questions when you do not understand information or instructions. If you believe you cannot follow through with your treatment, you are responsible for telling the doctor. You and your family members/friends are responsible for being considerate of the needs of the other patients and the staff. You are responsible for providing information regarding insurance and for working with office personnel to arrange payment when needed. Your health depends not just on your visits to the office but in the long term, on the decisions you make in your daily life. You are responsible for recognizing the effect of lifestyle on your personal health.

_____ _____

Signature of Patient Date

Beach Life Chiropractic

# Beach Life Chiropractic Center

## Financial Statement

1. **PROOF OF INSURANCE:** Please bring your insurance card(s) with you to every appointment. It is YOUR responsibility to inform the staff of Beach Life Chiropractic Center when the cause of treatment should be billed to another type of insurance, such as, auto insurance, liability insurance company or worker's compensation instead of your regular primary insurance.
   *Verification of your insurance benefits is a service provided to you at no charge. The information we receive about your benefits comes directly from your insurance carrier. This is not a guarantee of payment. If you have questions about your insurance benefits, please contact your insurance carrier directly.*
2. **PAYMENT IS DUE AT THE TIME OF BILLING:** We accept cash, personal checks, debit and credit cards. All deductibles, co-pays, and non-covered services are due at the time of the service unless arrangements are made in advance. I assign to Beach Life Chiropractic Center all money to which I am entitled for chiropractic expense relative to the service rendered. I understand that I am financially responsible to Beach Life Chiropractic Center for charges not covered by my insurance company.

   If you have Medicare, YOU will be required to sign a waiver (Medicare non-covered form) prior to treatment as Medicare may deem the treatment "medically unnecessary" according to HCFA payment guidelines and you will then be responsible for payment. All Medicare patients will be required to pay their co-pay unless proof of secondary policy is evident.

   If your co-pay is based on a percentage (example- 20% is patient responsibility) and you do not have a secondary insurance policy, please be prepared to your co-pay amount.

3. **FINANCIAL ASSITANCE:** If you have no insurance, have maximized your benefits, have a high deductible or you are currently medically or financially indigent but not eligible for Public Assistance, please ask to speak with our Financial Advisor.
4. **BILLING, PAYMENTS AND OVER PAYMENTS:** There may be services that are not covered by your health benefits contract. You will be expected to pay for those services in full. If you have any questions about whether a particular service is covered by covered by your health benefits contract, someone in our office will be happy to assist you. If an overpayment is made by you on the account, a refund will only be issued if there are no other outstanding debts on other accounts containing the same guarantor of financial responsible party. Patient balances unforeseen at time of service will be billed to the address you have provided for billing purposes. It is YOUR responsibility to inform us of any changes in address, phone or employment. All balances are due within 14 days of the billing date. If you cannot pay the balance within the 14 days, please contact our office to see if you qualify for any special payment arrangement options.
5. **PAST DUE AND DELINQUENT ACCOUNTS:** Failure to meet your financial obligations may result in reporting to credit bureaus, filing a judgement in small claims court or other collection action against you. All attorney fees, court costs and other expenses related to collecting your account will be added to your outstanding balance.

_____ _____

Patient or Responsible Party's Signature Date

Beach Life Chiropractic

**NOTICE OF PRIVACY PRACTICES**

THIS PRACTICE IS COMMITTED TO MAINTAINING THE PRIVACY OF YOUR PROTECTED HEALTH INFORMATION, (PHI), WHICH INCLUDES INFORMATION ABOUT YOUR HEALTH CONDITION AND THE CARE AND TREATMENT YOU RECEIVE FROM THE PRACTICE.

THE PRACTICE MAY USE AND/OR DISCLOSE YOUR PHI FOR THE PURPOSE OF:

(A) Treatment- To provide you with the health care you require, the practice will provide your PHI to those health care professionals directly involved in your care so we may understand your health conditions and needs.

(B) Payment- To get paid for services provided to you, the Practice would provide your PHI to those billing services pursuant to their billing and payment requirements.

(C) Appointment Reminder- The Practice may contact you to provide appointment reminder or information about your treatment benefits and services by mail at the address given by you or calling your home and leaving a message on your voicemail or with the individual answering the phone.

(D) Sign-In Log- The Practice maintains a sign-in log for individuals seeking care and treatment in the office. The sign-in log is in a position where staff can readily see who is seeking care, as well as the individual's seeking care in the office.

(E) Authorize Beach Life Chiropractic Center, Inc. to release any information including the diagnosis and the records of any treatment or examination rendered to me/or my dependent during the period of such care to third party payers and/or my dependent during the period of such care to third party payers and/or other health practitioners listed below.

Name: _____ Name: _____
Address: _____ Address: _____
Phone: _____ Phone: _____
Fax: _____ Fax: _____

THE INFORMATION MAY BE USED/DISCLOSED FOR EACH OF THE FOLLOWING PURPOSES:

- For my health care
- For payment/insurance
- For employment purposes
- Other: _____

AUTHORIZATION

Uses and/or disclosures, other than those described above will be made only with your written Authorization.

YOUR RIGHTS

1. You may request to review a copy of the HIPPA COMPLIANCE MA NUAL located in the Practice, which more detailed information regarding your privacy rights.

**Acknowledgement of Receipt of Notice of Privacy Practices**
**&**
**Patient and Emergency Contact Form**

****I hereby acknowledge receipt of Beach Life Chiropractic Center, Inc. Notice of Privacy Practices**

**Any Doctor, staff, employee, or representative of Beach Life Chiropractic Center, Inc. has my permission to discuss my account and medical conditions which may include, but are not limited to, appointment times, test results, symptoms, treatments, diagnosis, medications, billing or insurance information, or any type of protected health information with me or the person(s) listed below in order to facilitate and coordinate my care, treatment, and payment. I understand that signing this form is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to Beach Life Chiropractic Center, Ins. Or by completing a new form at any time. I also give permission for any of the above listed information to be left on a voicemail at any of my or the below listed numbers. I understand that information left with someone other than myself or via mechanical means, such as an answering machine, may be subject to redisclosure by the recipient and may no longer be protected by Federal and State Law.

****This form will be placed in the patient's chart and maintained for 5 years. ****

**Please ***PRINT*** a list of persons we may speak with:**

_____ _____ (____)_____
Name Relationship Phone Number

_____ _____ (____)_____
Signature Relationship Phone Number

# CONSENT TO TREAT

I do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of adjustments involving movement of the joints and soft tissues. Physical therapy and exercise may also be used.

The practice of chiropractic includes many standard examination procedures. These include physical examination, orthopedic and neurological testing, palpation, specialized instrumentations, laboratory tests, radiological examinations, physical therapy and rehabilitative procedures. Additionally, there is a procedure unique to the chiropractic profession – the chiropractic spinal adjustment. Adjustments may be performed on joints of the spine and extremities.

Although spinal adjustments are one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows: soreness, dizziness, fractures/joint injury, stroke.

Along with the doctor's examination, I have completed a case history and have discussed my history to minimize the risk of any complication from treatment and I freely assume these risks.

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm.

I am aware of reasonable alternatives to these procedures such as rest, home applications of therapy, prescription or over-the-counter medications, exercises, possible surgery, or nontreatment.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction prior to my signing of this consent form. I have made my decision voluntarily and freely. Having this knowledge, I authorize Beach Life Chiropractic Center to proceed with chiropractic care and treatment.

| | |
|---|---|
| Signature of Patient | Date |
| Signature of Witness | Date |

Beach Life Chiropractic

**Beach Life Chiropractic Center**
**1115-A N. McKenzie Street**
**Foley, AL 36535**
**251-943-8511**

## Disclosure of Fees

| | | |
|---|---|---|
| 99203 | New Patient Comprehensive Examination | $105.00 |
| 99213 | Expanded Service/Re-Examination | $80.00 |
| 98941 | Manipulation 3-4 Regions | $50.00 |
| 98940 | Manipulation 1-2 Regions | $44.00 |
| 97140 | Manual Therapy | $36.00 |
| 72040 | Cervical X-Rays | $65.00 |
| 72070 | Thoracic X-Rays | $75.00 |
| 72100 | Lumbar X-Rays | $85.00 |
| 97012 | Traction (Decompression Therapy) | $40.00 |
| 97014 | E-Stim (Muscle Stimulation) | $32.00 |
| 97035 | Ultrasound | $32.00 |
| 97039 | Intersegmental Traction/Rolling Table | $25.00 |
| 97032 | Unattended Stimulation | $30.00 |
| 97110 | Therapeutic Exercise/Procedure | $38.00 |

I have read the above codes and fees and understand the cost of my care at Beach Life Chiropractic Center. I understand that I am responsible for payment of all deductibles and co-payments related to my care. I understand that if I have a balance for medical expenses not paid, I will make a minimum payment of $50.00 each month or 25% of the outstanding balance, whichever is greater. If my balance is not paid in a timely manner, I promise to pay all collection, court, and attorney fees in the collection of my account. I further understand that if my treatment is associated with a personal injury or accident claim, all medical bills will be paid at 100% of the above fee schedule regardless of the outcome of my case. I understand if a check or debit is returned for insufficient funds, I will be charged a $35.00 service charge. I have read and fully understand the above financial terms and prices.

_____ _____

Signature of Patient Date

Beach Life Chiropractic