REGENERATIVE
HEALTH AND CHIROPRACTIC, LTD.

Patient Information

Name: _____
Last First MI

Email Address: _____

Mailing Address: _____

_____

Phone #: (Home) _____ (Cell) _____ (Work) _____ Primary Doctor _____

May we call you at work? □ Yes □ No Select One: □ Text Reminder □ Email Reminder

Date of Birth: _____ Sex at Birth: □ Male □ Female SS#: _____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Minor

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

How did you hear about our practice? _____

Emergency Contact: Name: _____ Relation: _____ Phone: _____

Accident Information

Is this visit due to an accident? □ Yes □ No If yes, What type? □ Auto □ Work □ Other _____

Was it reported? □ Yes □ No To whom? _____ Accident Date: _____
Claim #: _____ Claims Rep Name: _____ Claims Phone #: _____

Attorney Name: _____ Attorney Phone #: _____

Financial Information

Name of person responsible for this account: _____

Relationship to patient (if other than self): _____ Phone #: _____

Do you have health insurance? □ Yes □ No Name of Carrier: _____

Do you have secondary insurance? □ Yes □ No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (Insured Patients)

I certify that I (or my dependent) have insurance coverage with the company stated above and I AUTHORIZE, REQUEST, AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PROVIDER/MEDICAL PRACTICE, Regenerative Health and Chiropractic, LTD., INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all copayments, coinsurance, deductibles, and noncovered services. I hereby authorize the doctor to release all the information necessary, including the diagnosis and records of any exam or treatment rendered to me, to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE: _____ Date: _____

CONSENT TO CARE

A patient coming to the office gives his/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor or medical provider, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from (latent pathological defects, illnesses, or deformities) which would otherwise not come to the attention of the provider.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I have read and understand the foregoing.

SIGNATURE: _____ Date: _____

X-Ray Questionnaire: For Women Only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary, we would like to confirm that you are not pregnant at this time.

Name: _____

□ There is a possibility that I may be pregnant at this time.

□ Yes, I am definitely pregnant.

□ No, I am definitely not pregnant at this time.

□ I request that x-rays not be taken because: _____

Date of last menstrual period: _____

SIGNATURE: _____ Date: _____

PATIENT MISSED APPOINTMENT POLICY

DEFINITIONS
POLICY – a way of managing affairs to achieve some purpose.
APPOINTMENT – a meeting with someone at a certain time and place.
MISSED – failure to keep, do, or be present at.

It is our wisht that each and every one of our patients receive the very best care and service possible. **Your Treatment Program** consists of a specific series of treatment given over a pre-planned time span. If you do not follow this plan, you will not receive the desired results.

If we did not insist that you meet all of your appointments, we would be doing you a disservice and it would be indicative that we dd not care. We do not want to do you a disservice and we do care about you and the success of your program here. Therefore, we have a few simple rules that we insist you follow:

1. Meet all your appointments. Arrange the activities in your life so that this can occur.
2. If you have a cold, sinus issue or migraine, we still want you to come in, because **Treatments** will help you recover.
3. If you are unable to make it in due to an emergency, please call us and let us know so we can reschedule your appointment.
4. With the exceptions of unexpected emergencies or illness, we require that you notify us at least **24 hours** in advance for any appointment changes.
5. **All cancelled or missed appointments must be rescheduled and made up within one week.**
6. There is a $25 late fee if you are more than 20 minutes late to your chiropractic/rehab appointments, without notice, that is due when you arrive.
7. If you are more than 30 minutes late for your chiropractic/rehab appointments without notice you will be charged a $25 late fee and will need to reschedule.
8. There is a $25 service charge for no call/no show appointments for chiropractic/rehab appointments.
9. There is a $50 service charge for all Medical Provider appointments that are missed, no call/no show, late cancelation, and appointments where you arrive more than 10 minutes late.
10. Friday appointments are by appointment only. If you miss your appointment or cancel at the last minute you will be charged the associated missed appointment fee per provider.

I have read, understand, and agree to follow the above policy.

Patient Name: _____

Signature: _____

Staff Witness: _____

Financial Office Policies

1. All patients are on a cash basis until our staff can verify all insurance coverage(s).
2. Your insurance will be verified promptly and will be reviewed with you if applicable.
3. After coverage and deductible are verified, this office may accept assignment on most policies provided the insured/patient signs an appropriate statement of benefits and/or a lien authorizing payment to be sent to the doctor.
4. Waiting for the insurance payment is a courtesy and it may be withdrawn under certain circumstances.
5. As a patient, it is your responsibility to take care of the copayment, coinsurance, deductible, and any non-covered services on a per visit basis. This office may make payment arrangements on an individual basis. Any such plan or arrangements will be discussed during your report of findings.
6. This office does not warrant or guarantee that your insurance company will pay, nor does this office promise that an insurance company will or should pay the fees charged. Insurance policies are an arrangement between the insurance carrier and the patient/insured.
7. Any service not covered or coverage reductions by your insurance carrier will be the patient's responsibility.
8. This office will submit an insurance claim for you. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly with your insurance adjuster or agent. Any denied or disputed claims will be treated as uncovered.
9. If your account should go to collections for any reason, it will be the patient's responsibility for any court costs, attorney's fees, and or collection costs incurred in collecting the account balance.
10. Signing below authorizes the release of any medical/other records, or information from your health record; and authorizes release of records or information necessary to process any claims.
11. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due. This means refunds are made only after your balance is completed and cleared with this office.
12. If you receive correspondence of checks from your insurance company, you agree to bring these into our department so that we may determine if any action needs to be taken or if the check is on assignment to this office.
13. If you change insurance companies or employers, you agree to provide this office with the current information immediately.
14. If this office gives you any professional or accounting discount for treatment and you decide to drop out of care, then our standard fees will apply.
15. This office accepts MasterCard, Visa, American Express, Discover Card, Care Credit, personal checks, and cash.
16. If you have any questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the doctor.
17. If you stop care and have a financial agreement signed with our office, you will be responsible for any/ all charges that you have incurred at our office.
18. If your balance is not resolved within 30 days, there will be a $35 fee charged for every month unpaid.
19. All copays, coinsurances, and visit fees are due at the time of service unless other arrangements have previously been made with RH+C, LTD.
20. All patients must have a form of card payment on file.

Thank you for your cooperation in this matter.

I have read and fully understand the financial office policy and agree to abide by these terms.

_____ _____/_____/_____

Patient Signature or Responsible Party Date

Non-Assignment of Insurance Benefits Policy

If your insurance company does not assign benefits over to this office, meaning any amount due to Regenerative Health and Chiropractic, LTD is mailed to you (the patient) and not to this office, the following will apply:

Since my insurance company will not assign benefits directly to Regenerative Health and Chiropractic, LTD, I am opting to follow the below 'Non-Assignment of Benefits' policy.

Our office will treat you and you will be responsible to pay your deductible, copayment, or coinsurance that is due for each of your allowed visits by the insurance company. To do this, our office will need to have a credit card on file. As the insurance disburses funds to you (the patient), you are required to bring the payments to this office within seven (7) days. As you receive payments or an Explanation of Benefits (EOB), our office also receives a copy of what you received, minus any payments.

If we have not received the payment from you (the patient) within seven (7) days, our office will charge the amount that you received from the insurance company on the credit card on file. NOTE: We will only charge the credit card if the payment is not brought in within seven (7) days.

If unusual circumstances arise where you cannot bring the payment in, please call the office to let us know so the credit card won't be charged. (eg emergency, out of town, etc)

If the insurance company denies your claim, you will be responsible for services rendered.

I have read the above policy and my signature below indicates that I understand and agree to follow this policy.

Patient's Printed Name: _____

Signature: _____ Date: _____/_____/_____

Instructions:

1. Have the "insured" person of the policy sign the back of the check.
2. Bring the check and explanation of benefits (EOB) to our office within 7 days
   DO NOT DETACH THE CHECK FROM THE EOB.
3. Give the EOB/Check to the front desk when you arrive to our office. We will make a copy for your records.

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ DOB: _____

I acknowledge that I have been informed of the *Notice of Privacy Practices* of Regenerative Health and Chiropractic, LTD.

Please initial one of the following options:

_____ I wish to receive a paper copy of the Privacy Notice.

_____ I wish to receive an electronic copy of the Privacy Notice.

Email Address: _____@_____

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial below:

_____ I acknowledge that it is a policy of Regenerative Health & Chiropractic, LTD to leave reminder messages on my voicemail or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

_____ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer, Dr. Christina Darin, D.C., about my concerns.

_____ _____
Signature of Patient/Guardian Date

_____ _____
Staff Witness Signature Date

HIPAA Notice of Privacy Practices

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information that may identify you and that relates to your past, present, or future physical or mental health or condition and related healthcare services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your provider, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of the provider's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example, your protected health information may be provided to a provider to whom you have been referred to ensure that the provider has the necessary information to diagnose or treat you. Our rehab area is open.

Payment: Your protected health information will be used, as needed, to obtain payment for your healthcare services.

Healthcare Operations: We may use or disclose, as needed, your protected health information to support the business activities of your provider's practice. These activities include, but are not limited to, quality assessments, employee reviews, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your provider. We may also call you by name in the waiting room when your provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include as Required by Law, Public Health issues required by law, Communicable Diseases, Health Oversight, Abuse, Neglect, Food and Drug administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donation, Research, Criminal Activity, Military Activity, National Security, Worker's Compensation, and Inmates. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Our rehab area is open, thus, you are aware that any conversations you have about your treatment, health, and conditions outside of our exam rooms or provider's office are subject to being overheard by others.

Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your provider or the provider's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights:
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your provider is not required to agree to a restriction that you may request. If the provider believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e., electronically.

You have the right to have your provider amend your protected health information. If we deny your request for the amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints:
If you believe your privacy rights have been violated by us, you may issue a complaint directly to us or to the Secretary of Health and Human Services, to file a complaint with us, please notify our privacy officer of your complaint. We will not retaliate against you for filing a complaint. This notice was published and becomes effective on or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

_____	_____	_____
Printed Name	Signature	Date

I authorize Regenerative Health & Chiropractic, LTD to discuss my case, health, and finances relating to care with the following people:

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____