

Binder Family Chiropractic S.C.

Dr. Kellen and Amanda Binder D.C.

Please Print Clearly and Fill in Completely

CONFIDENTIAL PATIENT HEALTH RECORD

Date: _____

PERSONAL HISTORY

Name: _____ Birth Date: ____/____/____ Age: _____
Sex: Male Female
Address: _____ Apt: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone _____
Email: _____ Referred to this office by: _____
Occupation: _____
Name of Spouse: _____
Name/Number/Relationship of Emergency Contact _____

I understand that Binder Family Chiropractic may or may not be an in-network provider for my insurance plan. Binder Family Chiropractic will seek to verify my specific benefits as quickly as possible and advise me of such. Furthermore, I understand that this office will prepare any necessary reports and forms to ensure an efficient collections process from my insurance company, and the authorized amount will be paid directly to Binder Family Chiropractic and credited to my account upon receipt. However, I clearly understand and agree that I am personally and immediately responsible for payment if/when my insurance company denies payment, or applies claims to my deductible for any previously provided services.

Sign: _____ Date: _____

CURRENT HEALTH CONDITION

What brought you into the clinic?

I am here for Wellness/Preventative care

MECHANISM OF ONSET: Before you began to suffer with this problem, was there an earlier accident, injury, or condition that may have been directly related to this problem? (Such as a fall, an auto injury, sports trauma, or repetitive motion on the job?) _____

VERTEBRALSUBLUXATIONS IRRITATE DIFFERENT FIBERS IN NERVES; WHICH BEST DESCRIBES YOUR CONDITION:

Burning Diffuse Dull/Aching Localized Sharp Shooting Stabbing Tingling

Radiating Other: _____

DAILY ACTIVITIES

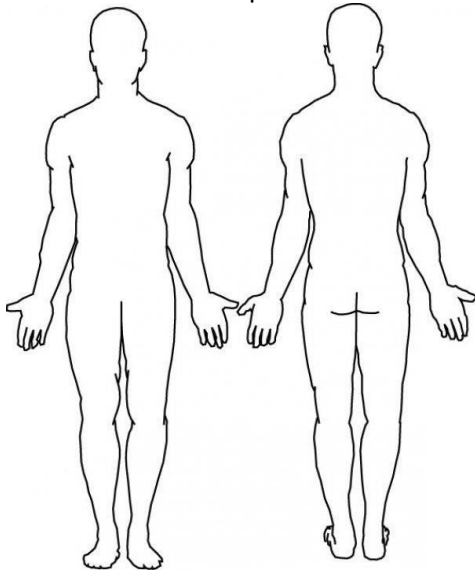
Carrying Groceries.....	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sit to Stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climbing Stairs.....	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pet Care.....	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving.....	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Extended Computer Use	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Household Chores.....	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lifting Children.....	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Reading/Concentration.....	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Bathing.....	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Shaving.....	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleep.....	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Sitting.....	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Yardwork... ..	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

SOCIAL HISTORY QUESTIONNAIRE**FAMILY**

History of Heart Disease? Paternal Maternal
History of Cancer? Paternal Maternal
Other? _____

Has there been any other injury to your spine you feel the doctor should know about? _____

Circle the areas where you have any problems.
Please also describe these problems.



Your Signature Below, Please:

Thank you for being completely thorough!

Date: _____



Patient Name: _____

Assignment of Insurance Benefits

I hereby authorize payment to be made directly to Binder Family Chiropractic, of all benefits which may be due and payable under insurance coverage for the above named patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to Binder Family Chiropractic.

Authorization to Release Medical Record Information

Binder Family Chiropractic is hereby authorized to disclose all or any part of the medical records on the above named patient to such insurance companies, organizations, or agencies as may be responsible for payment of services rendered by Binder Family Chiropractic. This authorization I give with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage for services rendered by said Chiropractor.

The undersigned certifies that he/she has read and understands each of the above paragraphs and is the patient responsible party with the power to execute this document and accept these terms.

Signature of Patient or Responsible Party: _____

Binder Family Chiropractic LLC, Financial Policy

Thank you for choosing Binder Family Chiropractic LLC. It is our policy to provide quality chiropractic services with minimal financial stresses. We are members of the most preferred provider networks to keep your costs low. We will file all insurance claims for your convenience. We also provide affordable cash plans for those without insurance or those who choose not to use their insurance.

Pre-Pays: All accounts are audited upon the cessation of care or end of care plan. Any pre-payment for services not rendered will be refunded or applied to future care as directed by patient. Payments are applied to services not rendered; not based on time. Any pre-payment savings given at the beginning of care for decreased bookkeeping costs are therefore not given if audit before the end of care plan is needed and bookkeeping costs arise because of this. This previous credit will be deducted from any refund amount.

As with all medical procedures, payment of service does not guarantee or imply cure. Individual results are reliant on a multitude of internal and external factors which in no way can be guaranteed. Payment is expected irrespective of outcomes. Healing takes both time and repetition.

• All payments are due upon receipt

If an account balance becomes greater than 90 days past due and if no other prior payment arrangements have been made, the account will be turned over to our collections department. You will be responsible for all collection agency fees above and beyond your past due balance.

I have read and understand the financial policy:

Signature _____ Date _____

TERMS OF ACCEPTANCE

CHIROPRACTIC INFORMED CONSENT

Patient Name: _____

When a patient seeks chiropractic health care and we agree to provide this care, it is essential for the patient and Binder Family Chiropractic to be working toward the same objective. It is important that each patient understand both the objective and the method with which it will be obtained. This prevents any confusion or disappointment.

Adults: Chiropractic care can be successful at any age. The longer the subluxation has been there and the more damage that has been done, the longer it will take to correct and stabilize, and the more often you will need adjustments in order to maintain a healthy spine and nervous system. Healing takes both time and repetition.

Kids: Children's spines are very sensitive, and improper alignment as a child can lead to permanent spinal impairment as they grow. Children get quick and profound results for a number of conditions clearly related to subluxation; therefore, it is best to check children for subluxations and begin any necessary treatment as young as possible.

Duration of care: While pain relief may only take a few visits, getting well takes time. Depending on the patient's age, subluxation severity and lifestyle, adjustment and rehabilitative schedules for correction can range from six months to two years. Following correction, the doctor will make a recommendation for wellness care.

As a rule, informed and cooperative patients can achieve positive chiropractic results. Thus, the following information is routinely supplied to all who consider Chiropractic care. While recognizing the benefits of a healthy nervous system, you should also be aware that, like all areas of the healing arts, response to treatment and results cannot be guaranteed.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Binder Family Chiropractic will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Binder Family Chiropractic and will be credited to my account upon receipt. However, I clearly understand and agree that all my services rendered are charged directly to me and that I am personally responsible for payment.

I, _____, have read and fully understand the above statements.
(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I, therefore, accept chiropractic care on this basis.

Signature: _____ Date: _____

Consent to evaluate and adjust a minor/child: 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.

Signature of parent/legal guardian: _____ Date: _____

Pregnancy Release: This is to certify that to the best of my knowledge, I am not pregnant. The above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Signature: _____ **Date:** _____

NOTICE OF PRIVACY PRACTICE (NPP):

- **To Family and Close Friends Involved in Your Care:** Our office has an open, family centered approach to wellness and we believe it is in all our patients best interests to have the support and cooperation of their families. Therefore, our office strongly encourages that the spouse or significant other be present when the doctor goes over the patients report and recommendations for care.

In addition, we may disclose your PHI (Personal Health Information) to a family member or a close friend if those persons accompany you while you are receiving health care services; or if we determine that it is in your best interest so we can provide you with the best health care possible. We may also disclose your PHI to a family member or someone else who helps pay for your chiropractic care.

- **Right to Inspect and Copy:** You have the right to inspect and copy PHI that may be used to make decisions about your care. Usually, PHI includes medical and billing records. To inspect and copy PHI, you must submit your request in writing on the form provided by our practice.

Signature: _____

Date: _____

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

In the course of your care as a patient at Binder Family Chiropractic, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your medical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
 - Your health care records, as well as your billing records, may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
 - Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be an interest to you.
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If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide us with this authorization; it will not affect the care provided to you, or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
 - If we provide health care services to you in an emergency.
 - If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
 - If there are substantial barriers to communication with you, but in our professional judgment we believe that you intend for us to provide care.
 - If we are ordered by the courts or another appropriate agency
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Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible, following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Name (Printed)

Signature

Date

****If you are a minor, or if you are being represented by another party:***

Representative (printed name)

Signature

Date