Welcome to Koelling and Turnbull Chiropractic Center

Patient Name:_____
Insured's Name (if same as patient put "same"):_____

Patient's Address:_____
City_____ State_____ Zip_____ Home #_____

Work #_____Cell #_____Email_____
Social Security #_____Age:_____ Date of Birth:_____

Insured's Address (if same as patient put "same"):_____
City_____ State_____ Zip_____ Home Tel#_____

Your employer_____

Primary Insurance_____
Secondary Insurance_____

Spouse's Name:_____ Date of Birth:_____
Social Security #_____ Spouse's Employer_____

What medications are you taking?_____
What surgeries have you had and when?_____
Who is your primary physician?_____

Please list your complaints in order of severity:

1._____How long?_____
2._____How long?_____
3._____How long?_____

Date of first symptom?_____
Female History: Date of last menstrual cycle?_____
Are you pregnant at this time?_____

In case of emergency, please give the name and phone number of your nearest relative that does not live with you: _____

How did you hear about our office? _____

My signature below represents the following:
I understand that my health and accident insurance policies are an agreement between the insurance carrier and myself. I authorize Koelling and Turnbull Chiropractic Center, P.C. to release all medical information from my records to aid in the collection of insurance benefits. I authorize insurance payments to be paid directly to Koelling and Turnbull Chiropractic Center, P.C. In the event that the insurance company, liable party or attorney should pay me, I will forward all checks to Koelling & Turnbull Chiropractic Center, P.C. within five business days. I agree a photocopy of this document will be deemed as valid and binding as the original. I understand that the services rendered are charged to me and in the event that the insurance company, liable party, or attorney refuses to make payment for any reason, I am directly responsible for making full payment within 15 days of my first statement. I also agree and understand that if my account becomes delinquent and goes to collection, I will be responsible for all fees necessary to collect on my account.

Signature of Responsible Party_____Date_____

Koelling & Turnbull Chiropractic
Financial Policy

GROUP OR INDIVIDUAL INSURANCE: Your insurance is an agreement between you and your insurance company, not between your insurance company and this chiropractic center. We are not certain if your insurance covers chiropractic, although most policies **do** provide coverage. The amount they pay varies from one policy to another. Because of this difference between policies, we expect that each patient who wishes to file insurance claims through this office, pay the insurance policy deductible and the patient's percentage or copay as stated in your policy. As a courtesy to our patients, our office will complete any necessary insurance forms at no charge, and file them with your company to help you collect. We allow one resubmission of claims at no charge. If your insurance company fails to process the claims after a second submission you will be required to pay for services and seek reimbursement from your insurance company. It is to be understood and agreed that services rendered are charged to you directly and you are personally responsible in the event that your insurance company denies payment. We will assist you in verifying your insurance coverage however, it is your responsibility to know the provisions of your particular policy. When all insurance checks have been received, we will refund any overpayment to you.

PATIENTS WITHOUT INSURANCE: An increasing number of patients do not have insurance, or have plans with limited coverage, such as catastrophic policies. We realize that no one wants to build up a large bill. Therefore, we have several plans so those patients may receive complete care without undue financial difficulty. Of course we are always happy to accept cash, your personal check, Mastercard, or Visa. We request that 100% of the first visit be paid at the time of the first visit.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS: Please present your auto insurance forms as soon as possible. If an attorney is handling your case, please notify the insurance department right away. Although you are ultimately responsible for your bill, our office will wait for settlement to be paid as long as you are an active patient and do not have major medical or medical payments coverage. We do not accept provider discounts because the liability carrier or medical payments coverage is the primary insurance company all others are secondary. If you suspend or terminate care, any fees and services are due immediately. We will contact your attorney and insurance companies to begin settlement procedures upon release from active care. If your case is not settled with in 90 days from your release, we will require you to make partial payments of 20% of your outstanding balance for the next 5 months. At any point settlement is reached, your account is due and payable in full immediately.

MEDICARE: We do not accept assignment from Medicare. The check is usually sent directly to you in payment of services that Medicare will cover. For Chiropractors this includes only manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. The patient is also responsible for payment in full of all covered and non-covered services when they are rendered. Subsequent services will be payable at each visit unless other arrangements are made. Our office will complete the necessary forms and file them with the Medicare provider at no charge. We allow one resubmission of your claim at no charge.

"**ON THE JOB INJURY**": Worker's Compensation pays in full for Chiropractic care when approved by your employer. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if settlement has not been made within 3 months, or if you suspend or terminate care, any fees and services are due immediately.

**Regardless of which plan you are under, you will be required to pay for all products, durable supplies, orthotics, nutritional supplements etc. at the time they are provided to you.

Note: Your health information will be kept confidential. Any information we collect about you will be kept confidential in our offices. If a claim is submitted to an insurance provider your health information may be shared with the insurance company. The insurance company will keep your information confidential.

Signature_____ Date_____

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operation we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of the PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____ _____

Signature Printed Name Date