1641 Venture Dr., Mount Vernon, Ohio 43050
P: 740-397-1212   F: 740-397-4301

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change. If so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? Yes ____ No ____

May we leave a message on your answering machine or your cell phone? Yes ____ No ____

May we discuss your medical condition with any member of your family? Yes ____ No ____

If Yes, please name those members allowed: ____

____

This consent was signed by (Please Print Name): ______________________________

Signature: ________________________________ Date: ________________

Witness: _________________________________ Date: ________________

Informed Consent to Treat

I hereby give Mark Boynton, DC or other licensed Doctor of Chiropractic who now or in the future work at the clinic(s) or office(s) listed below consent to the performance of nutritional/functional medicine counseling, chiropractic adjustments, diagnostic x-rays on me, family members or the patient named below for whom I'm legally responsible, and other chiropractic procedures. These may include various modes of physical therapy, massage therapy, muscle stimulation, ultrasound, stretching, vibration therapy and dry needling.

I have had an opportunity to discuss my health care needs, nature and purpose of chiropractic adjustments, other procedures and counseling with Mark Boynton, DC and/or with the other office or clinic personnel. I understand that the results are not guaranteed.

I understand in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate or explain all risks and complications. I wish to rely upon the doctor to exercise judgement, based upon the facts then known to him or her, in providing treatment which the doctor feels is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Printed Name: __________________________

Signature: ______________________________

Date: ____________

Financial Policy

Thank you for choosing Family Chiropractic and Nutrition, LLC. We are committed to providing you with the best care possible. This goal is best achieved by letting you know in advance of our financial policy, which is an agreement between the doctors of the practice and the patient. Your clear understanding of the financial policy agreement is important to our professional relationship. Please read this carefully

and if you have questions please do not hesitate to ask a member of our team. We require a signature to document that you have read and understand these policies.

INSURANCE

- We must emphasize that as providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility from the DATE SERVICES ARE RENDERED. Therefore, it is necessary for you to know the benefits your insurance plan provides for you.
- A current insurance card must be presented at check in for every visit. If the insurance company that you designate is incorrect, you will be responsible for payment.
- We will not bill another insurance carrier supplied later if it is past the timely filing period for that insurance company. If you are insured by more than one insurance company, our office needs to have all insurance policies on file. If you have two commercial plans, we will only bill the primary policy and will supply a superbill at your request if you want to bill any remainder of your bill through your second policy.
- According to your insurance plan, you are responsible for all co-payments, deductibles, and coinsurances. When we verify that your deductible has not been met, we will collect up to our contracted rate with your insurance company at the time of service. Any amount due after your insurance company processes the claim and notifies Family Chiropractic and Nutrition, LLC will be billed directly to you.
- Co-Payments are due at time of service. Co-payments are a contractual obligation between you and your insurance company. If multiple family members are being seen, they will have a separate charge and co-payment collected as required by insurance.
- If your insurance company does not cover a service, the amount must be paid in full within 30 days of denial from the insurance company. If not insured, Family Chiropractic and Nutrition will allow you to pay out of pocket at a discounted rate. That amount is due at the time of service.
- Insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered. It is your responsibility to understand your benefit plan, including needs for referrals or authorization for specialty care, lab tests and other services that may be required. Please note physicians follow accepted national guidelines when determining your charges. They must code based upon what services were provided and cannot consider health plan benefits.

BILLING

- We will provide you with an itemized statement each month when there is a balance due. We accept cash, checks, MasterCard, Visa, Discover, American Express.
- We will charge your account a $35 non-sufficient funds charge if your check is returned to us for insufficient funds.
- We appreciate the difficulties involved in divorce and court orders. Family Chiropractic and Nutrition will not participate in disputes between custodial and noncustodial parents regarding our patients who are minors. We will refer to the responsible party as the person who signs the financial policy, for reimbursement of any amounts due.
- Balances are due within 30 days of the first statement unless prior arrangements have been made with the billing department. Please call if you have questions about your bill. Most problems can be settled quickly and easily, and your call will prevent any misunderstandings.
- Staff will be collecting payments at check in on all accounts with balances that are more than 30 days past due. If you are having difficulty paying your bill, please discuss the situation with one of the members of our team.
- Should your account remain outstanding more than 90 days, a final letter will be issued. Balances not paid in full within the 10 days of the date on the final request letter may be forwarded to an outside collection agency.
- Past Due Accounts: If your account becomes past due, we will take the necessary steps to collect that debt. We will make every attempt to set up payment arrangements with families that are going through a financial hardship. If we must refer your account to a collection agency, you may be charged additionally for any collection agency costs incurred. If we must refer collection of the account to an attorney, you may be charged additionally for any attorney fees we incur, including court costs. Please note that if your account is referred to a collection agency or an attorney for collection, the physicians of Family Chiropractic and Nutrition may no longer be able to provide care for you and/or your family. In this case the guarantor of the account will be notified by certified mail and will be given adequate time (30 days) to find a new provider.

Cancellation Policy

- At Family Chiropractic and Nutrition, LLC we strive to provide a family friendly environment while offering the best care for our patients. We greatly value our patients and understand their

time is very valuable and we'd like you to understand that our time is valuable as well. We all have families and understand life can be unpredictable and busy. As we do our best to respect your time in our office, we hope you will show us the same courtesy and honor our time by showing up for your appointment on time.

- With this in mind, we understand that life gets in the way sometimes. For example, the kids get sick, the car won't start or a meeting is running late. While nobody can guarantee 24 hours notice of an illness, we would appreciate as much notice as possible. If you do not reach out to us by your appointment time it will be considered a missed appointment. We would like to graciously extend one freebie a year. After that point we will charge a $40 fee to your credit card on file for any future missed appointments. We will call to inform you of this charge and we will only use this card information to apply missed appointment charges. It will be up to the ownership to consider any extenuating circumstances.
- Along with the above statement if you show a pattern of repetitive last-minute cancellations, we reserve the right to apply the missed appointment charge to your account and will notify you of such actions. You must understand that when you fail to notify us about your absence without adequate time, we may be unable to fill that time slot which reduces our ability to help more people, and that is why we're here.
- Lastly, while we hope it never comes to this, if you fail to notify us three consecutive times, we may have to terminate our relationship with you.

Thank you for understanding. If you have any questions please don't hesitate to ask.

FINANCIAL AGREEMENT

We appreciate your compliance with these policies. We strive to provide excellent, cost-effective care in an ever-changing health care environment. We are happy to discuss any questions you have about these policies.

The undersigned agrees with the terms and conditions listed in the financial policy. By refusing to sign this financial policy, I agree to pay in full at the time of service. I certify that the information I have given to Family Chiropractic and Nutrition, LLC is accurate. I hereby authorize Family Chiropractic and Nutrition to furnish my insurance company all they may request concerning the patient's present illness or injury. I hereby assign to Family Chiropractic and Nutrition all benefits for service rendered.

I have read and understand the Financial Policy from Family Chiropractic and Nutrition. I agree to adhere to the above written policies, and all questions have been answered.

Printed Name: _________________________

Signature: _____________________________

Date: _________________

New Patient Form

Patient's Name: ________________________ Nickname: ___________ Date of Birth:___/___/_____

Age:________ Gender at birth:____ M ____ F Marital status: Y / N

Address: _____________________ City: ____________________ State: ______ Zip Code: ________

Cell Phone/Home Phone: ________________ Wireless Carrier: ______________

Email: ______________________

Highest Education Level: High School ____ Under-Grad Degree ____ Post-Grad Degree ____

Job Title: ______________________________ Hours per week: __________

Nature of Business: _______________________________________

Genetic Background: Place a check mark next to your selection(s). African American ___ Asian ___

Caucasian ___ Hispanic ___ Mediterranean ___ Native American ___ Northern European ___

Other: _____________________

Emergency Contact Name: __________________________ Relationship: _________________

Telephone:_______________________

How did you hear about our office?____

Primary Insurance

Insurance company name: ____

Policy holder's name: ___________________________ Policy holder's date of birth: ________________

Member ID: _____________________________ Group ID: ______________

Relationship of patient to policy holder: ______________________________

Secondary Insurance

Insurance company name:____

Policy holder's name: ___________________________ Policy holder's date of birth: _______________

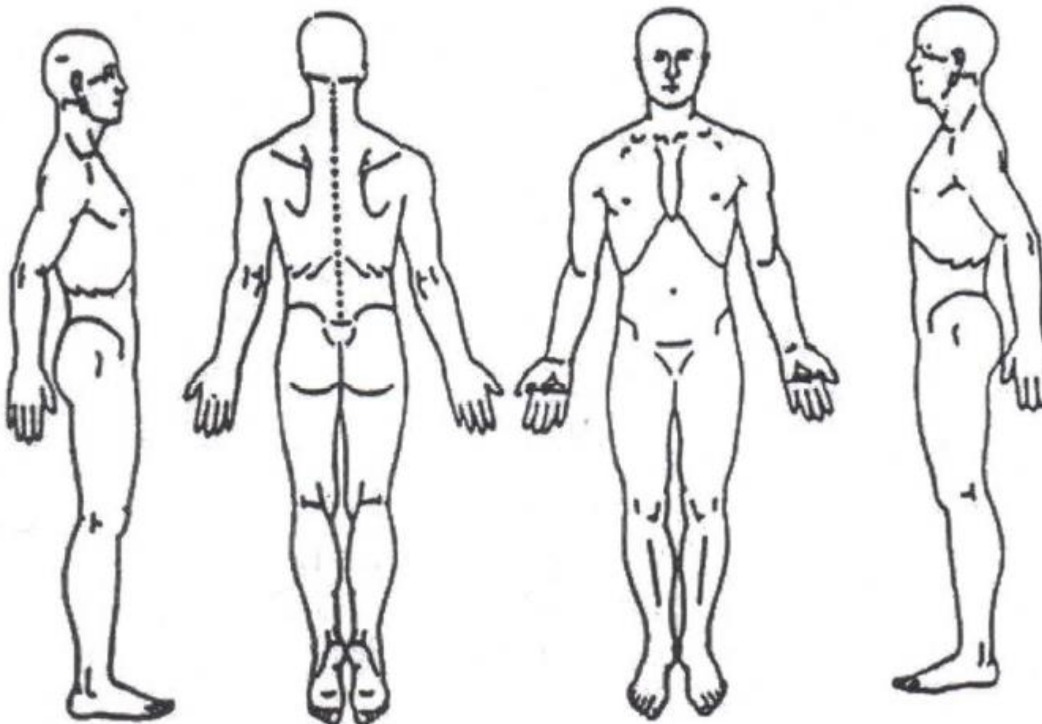
Member ID: _____________________________ Group ID: ______________

Relationship of patient to policy holder: ______________________________

Current and Ongoing Complaints

Problem/Location	Date of onset	Frequency	Treatment Approach	Pain Type	Severity 0-10
ie: low back		Constant	Chiropractic, meds	Sharp/dull	

Please circle the corresponding painful areas below:



What seems to make you feel better? ____

What seems to make you feel worse (certain movements, weather changes, etc.)?

____

If you could make only one improvement in your health, what would it be? ______________________

____

Is your pain due to an injury? ____ Yes ____ No If yes, please describe the injury and the date it occurred: ____

____

If no, please describe how long you have had this pain and what you believe it is caused by:

____

____

Please rate your overall health: Poor 0 1 2 3 4 5 6 7 8 9 10 Excellent

Please rate your energy levels: Poor 0 1 2 3 4 5 6 7 8 9 10 Excellent

Height (feet/inches): ________ Current weight: _________

Desired weight: __________ Highest adult weight: __________

Please list all medications and supplements you are currently taking

Medication/supplement	Dose if known	Frequency	Length of time taken	Reason for taken

Medical History

Current or past medical conditions (list date of diagnosis or onset): ___ None

____

____

____

Accidents or Major Trauma / Injuries (list month and year): ___ None

____

____

____

Surgeries/Hospitalizations (list month, year, reason) including cosmetic surgery: _____ None

____

____

____

Family Medical History

List any major illnesses for each family member. If deceased, give cause of death and age at death:

Mother: ____

Father: ____

Maternal grandparents: ____

Paternal grandparents: ____

Brothers/sisters: ____

Please list any other complaints or information not previously mentioned: ________________________

____

Symptoms Review

Never	Past	Current	
			Aches/Pains, sensitive to touch
			General Weakness
			Cold hands and feet
			Easily fatigued or exhausted
			Difficulty falling/staying asleep
			Nightmares
			No dream recall
			Daytime sleepiness
			Sleep less than 8 hours a night
			Need for caffeine to really wakeup
			Feel unrefreshed upon waking
			Worn out with little effort
			Feel worse standing, legs heavy
			Considered sickly or in poor health
			Hands tremble slightly for no reason
			Balance problems

Never	Past	Current	**Lower Back**
			Sciatica pain radiating down leg(s)
			Bulging or herniated disc
			Traumas or fractures
			Numbness or tingling in legs
			Foot Drop
			Any previous or ongoing diagnosis

Neck

Never	Past	Current	
			Stiffness
			Lumps/swelling
			Neck glands swell
			Goiter

Females only

Never	Past	Current	
			Are your periods every 28
			Are they painful
			Are you irritable
			Difficulty getting pregnant

Never	Past	Current	**Head/Neurological**
			Poor concentration
			Confusion
			Brain fog
			Indecisive
			Head feels heavy
			Hair loss/premature gray
			Hair dry and brittle
			Face twitch
			Numbness/tingling anywhere
			Dizziness
			Headaches
			Frequent ☐ Occasional ☐
			Severe ☐ Moderate ☐
			Mild ☐
			Location _______________
			Morning Afternoon
			Concussion/Whiplash

Never	Past	Current	**Musculoskeletal**
			Weakness in arms/legs
			Injure/sprain/strain easily
			Sharp/shooting/throbbing pain
			Morning stiffness
			Cramps/spasms
			Aching muscles not from exercise
			Favor one side sitting/walking
			Difficulty bending forward
			Difficulty reaching overhead
			Joint swelling/pain/stiffness
			Restless legs at night

Lifestyle History

Do you currently smoke? Yes No

If yes, how many packs per day? ____

Are you frequently exposed to secondhand smoke? Yes No

Rate your history of alcohol intake (1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits)?

None Mild Moderate High

How many drinks do you consume per week? None 1-3 4-6 7-10 >10

Average hours of sleep per night? ________

Do you exercise regularly? _______ Do you have a sedentary job? ______

Current exercise program? ____

Are you extra tired after exercising? Yes No Do you sweat when exercising? Yes No

Do you feel you have an excessive amount of stress in your life? Yes No

Do you feel you handle stress well? Yes No

Are you happy overall? Yes No

Hobbies and leisure activities: ____

Nutritional History

How many meals do you eat out per week? ____ 0-1 ____1-3 ____3-5 ____>5 meals per week

Do you read food labels? ____ Yes ____ No

Have you made any changes in your eating habits because of your health?____ Yes ____ No

The most important thing I should change about my diet to improve my health is? __________________

____

Do you currently follow any particular diet or nutritional program?_____ Yes ____ No

____Gluten-Free ____Low-Carb ___Dairy-Free ____Vegetarian ____Blood Type ____Other

How many servings of fruits and vegetables do you eat per day? ________________________________

What types of beverages do you consume? ____

How much water do you drink daily? _______

FAMILY
CHIROPRACTIC AND NUTRITION

Do you have symptoms immediately after eating? ____ Yes ____ No

Specify symptoms and any associated foods: ____

When you miss meals or go without food for extended periods of time, do you feel weak, dizzy, hangry, irritable (explain)? ____

Frequency of bowel movements (daily or weekly)? ____

Please list anything not covered on this form that you would like us to discuss: ______________________

____

____

Thank you for choosing us to partner with you in your wellness journey, we look forward to the adventure!

Patient Signature: ______________________________

Patient Printed Name: __________________________

Todays Date: ____________