



FAMILY

CHIROPRACTIC AND NUTRITION

1641 Venture Dr. Suite C, 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: _____

Pediatric New Patient Intake Form 13-17 years

Date: _____ Child's Name: _____ Nickname: _____

Parent/Guardian(s) Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Cell Carrier: _____

Emergency Contact Name: _____ Phone Number: _____

Relationship: _____

E-mail: _____ Birthdate: _____ Age: _____ Gender at birth: M / F

Weight: _____ Height: _____

Have you or your child ever had chiropractic care before? Yes No

If yes, please tell us the doctor's name: _____

Were you pleased with your care? Yes No

How did you find out about our office? _____

Is this appointment related to an auto accident? Yes No

If this injury is related to an auto accident, please fill out the Auto Accident Questionnaire.

Is your child receiving care from other health professionals? Yes No

If yes, please name them and their specialty: _____

Who is your family's primary care physician? _____

Please list any drugs or medications your child is taking: _____

Please list any vitamins/herbs/homeopathies/ other your child is taking:

Please list any allergies your child has: _____

What health condition brings your child to our office? _____

When did the symptoms first begin? _____

How did the problem start? Suddenly Gradually Post-Injury

Is this condition: Getting Worse Improving Intermittent Constant Not Sure

What makes the problem better? _____

What makes the problem worse? _____

Has your child ever had a similar condition? Yes No

If yes, please explain: _____

Has your child been treated for this problem before? Yes No

If yes, please explain: _____

Does your child eat well? Yes No

What are your child's top 5 food choices? _____

Does your child have regular daily bowel/bladder movement? Yes No

Has your child ever been checked for vertebral subluxations? Yes No Don't Know

Patient/Hospitalization/Surgical history (please list below all surgeries and hospitalizations, including the Year): _____

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including the year: _____

Please list any foods/juice intolerance: _____

Any pets at home? Yes No

Any smokers at home? Yes No

Has child received any vaccinations? Yes No

If yes, which ones and list any reactions: _____

Has child received any antibiotics? Yes No If yes, how many times? _____

Any behavioral problems? Yes No If yes, please explain: _____

Any night terrors, sleepwalking, or difficulty sleeping? Yes No If yes, please explain: _____

Does your child have difficulty in school with attention or focus? Yes No

Does the child have any siblings? Yes No If yes, the ages? _____

Do the siblings have any health problems and concerns? _____

Are there any conditions that run in your immediate family? _____

Do you know what a subluxation is? Yes No

Do any of your friends or relatives see a chiropractor? Yes No

If yes, do they use chiropractic for: Health maintenance/optimization Health problems Both?

Are you seeking chiropractic for: Health maintenance/optimization Health problems Both

What would you like to gain from chiropractic care? _____

Does your child have any rashes or bumps on their skin? If so, where? _____

Does your child have a problem with acne? Yes No

What sport or activity is your child involved in? _____

Are there other health concerns or anything else you'd like us to know about your child?

Parent/Guardian Signature: _____

Parent/Guardian printed name: _____

Date: _____