BRIXTON Chiropractic & ACUPUNCTURE

Today's date:	

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Married / Divorced / Separated / Widow

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Nickname:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

Email	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend Name _____ ❑ Groupon ❑Other

On a scale of 1-10 how interested are you in chiropractic care? _____ Major Complaints:

INSURANCE INFORMATION

(Please give your insurance card to the front desk.)

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Brixton Chiropractic and Acupuncture, insurance company, adjuster, or attorney involved in this claim to release any information required to process my claims. I give consent to the doctor and his/her staff to administer treatment and perform such procedures as deemed necessary in the diagnosis and treatment of named patient.

_____ _____

Patient/Guardian signature *Date*

Medical History

Date_____

Name_____

Check all that apply

	Past	Now	Family
Lung disease			
Heart disease			
Stomach disease			
Bladder disease			
Liver disease			
Kidney disease			
Colon disease			
Thyroid disease			
Circulatory disease			
Mental/Emotional disorder			
High blood pressure			

	Past	Now	Family
Low blood pressure			
Arthritis			
Swollen/Painful joints			
Recent weight loss/gain			
Diabetes			
Seizures/Epilepsy			
Cancer			
HIV/AIDS			
Arteriosclerosis			
Polio			
Rheumatic Fever			

Have you had:

	6 mths	6–18 mths	18+ mths	never
Spinal exam				
Physical exam				
Eye exam				
Chest X-ray				

	6 mths	6–18 mths	18+ mths	never
Spinal X-ray				
Dental X-ray				
Blood test				
Urine test				

Frequency

	Alcohol	Coffee	Tobacco	Exercise	Sleep	Appetite	Sweets
Heavy							
Moderate							
Light							
None							

List any conditions not found above about yourself or your family:

_____

_____

List any surgeries and/or accidents and the dates:

_____

_____

List vitamins, mineral supplements, and current medications and reason taken:

_____

_____

List any known or suspected allergies:

_____

Date of last chiropractic exam: _____ by Dr._____

Financial Policies

We are committed to providing you with the best possible care and will discuss our fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. **Please** ask if you have any questions regarding our fees, financial policy, or your responsibility. We accept cash, checks, and MasterCard/Visa.

INSURANCE: Group insurance is an agreement between you and your insurance company, not between your insurance company and your doctor. As a courtesy to our patients, our office will complete and file your claims on standard forms at no charge. We are credentialed by most insurance plans. The amount they pay varies from one policy to another. Because of the difference between policies, we request that each patient pay the deductible, percentage, and/or co-pay as stated in your policy.

PATIENTS WITHOUT COVERAGE: Payment is expected at the time of service **unless** arrangements have been made at the front desk prior to being seen by the doctor. We accept cash, checks, and credit cards.

PERSONAL INJURY/AUTO ACCIDENTS: We will file your claim with the appropriate insurance carrier (**your** health insurance and/or auto med-pay), and the third party carrier (the other person's insurance) as you are treated and file a Physician's Lien to assure payment. The third party carrier will not pay until settlement is reached. To prevent your premium from being affected due to a claim being made, even if you were not at fault, you may need to inform the third party insurance carrier to subrogate upon settlement of your claim; any balance will be forwarded to you. You agree **not** to allow your attorney to reduce our fees for their/your profit. When released, a 90-day time period is allowed for settlement. If you have not settled with the third party carrier within this time, or if you have suspended/terminated care without your doctor's approval, the balance of your account is due immediately.

WORKER'S COMPENSATION: Worker's compensation pays in full for chiropractic care when authorized by your employer, the insurance carrier, or the Oklahoma Worker's Compensation Court. Without written and/or verbal approval, payment is expected at the time of service, unless arrangements have been made at the front desk prior to that service.

MEDICARE: We do accept assignment from Medicare. Medicare will pay 80% of the **allowed** services, which in chiropractic offices includes only manipulations. They **do not** pay for exams, x-rays, or physical therapy modalities in a chiropractor's office. **Please read and sign "Explanation of Chiropractic Benefits for Medicare" before any services are rendered.**

STATEMENTS: To reduce our costs and create savings for you, we expect timely payments to be received per any agreement you have made with this office. Statements will be provided upon request. We make every attempt to double-check each statement's accuracy to let you know what is due. If you feel there is a mistake, please contact us. If you receive a statement and have not requested it, your account is considered past due.

PAST DUE ACCOUNTS: All accounts 90 days past due will be pursued for collection and/or reported to the Oklahoma City Credit Bureau unless arrangements are made.

Please remember that you are responsible for timely payments and settlement of your account.

By your signature below, you acknowledge having read and agreed to the Financial Policy of Brixton Chiropractic & Acupuncture.

Responsible Party Signature _____ Date _____

Witness Signature _____ Date _____

Patient Health Information Consent Form

We want you to know how 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 operations, 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 PHI, we encourage you to read the HIPAA 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, health care 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 their 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 affect 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 patient record privacy and a privacy official has been designed 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 purposes 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.

Name _____ Date _____

PLEASE PRINT

I verify that this information concerning who has access to PHI and what types of PHI is requested in this clinic and current.

Signature _____ Date _____

Brixton Chiropractic and Acupuncture

Patient Acknowledgement and Receipt of Notice of

Privacy Practices Pursuant to HIPPA and Consent for Use of Health Information

Name: _____ Date: _____

Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPPA and has been advised that a full copy of this office's HIPPA Compliance Manual is available upon request.

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPPA, The HIPPA Compliance Manual, State Law and Federal Law.

Dated this _____ day of _____, 20___

By: _____

Patient's Signature

If the patient is a minor or under a guardianship order as defined by State Law:

By _____

Signature of Parent/Guardian (circle one)