Kirwan Chiropractic Centre

4708 W. Plano Pkwy., Ste. 300, Plano, TX 75093 (972) 265-8100

Name: _____ Date: _____

Address: _____
City State Zip

E-mail: _____ Cell #: _____ Home #: _____ Work #: _____

Birth Date: _____ S.S.#: _____

__Single __Married __Divorced __Widowed Number of Children: _____

Occupation: _____ Employer: _____

Spouse Name: _____ Spouse Occupation: _____

Who may we thank for referring you to our office: _____

As a full spectrum chiropractic office, we focus on your ability to be healthy. Our goals are first to address the issue that brought you to our office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual, not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

Reason for seeking chiropractic care: _____

Other issues to discuss with the doctor: _____

When did you first notice this condition: _____

Have you ever had this before: __Yes __No When: _____

If experiencing pain, describe it:
__Sharp __Dull __Burning __Throbbing __Aching __Tingling __Constant __Travels
__Comes & Goes

What makes it worse:
__Sitting __Standing __Walking __Bending __Lying Down Others_____

Since the problem started has it: __Gotten better __Stayed the same __Getting worse

Other doctors seen for this condition:
__Chiropractors __Yes __No Who: _____ When: _____
__Medical Doctor __Yes __No Who: _____ When: _____
__Other __Yes __No Who: _____ When: _____

Please circle all symptoms you have had in the past 6 months even if they do not relate to your current problem.

Low back pain Shoulder pain Weight trouble Neck pain Hip pain Tension across shoulders

Pain between shoulders Knee pain Tingling/Numbing in arms Tension/Headaches

Ankle/Foot pain Tingling/Numbing in legs Tired or Fatigued Ringing in ears Dizziness

Wrist/Hand pain Allergies Nervousness Elbow pain Digestive troubles Difficult sleeping

Loss of balance Irritability Stress Heartburn Constipation Diarrhea Cold hands Cold feet

Depression Hot flashes Ulcers Light bothers eyes

From birth to present:
Car Accidents (even minor ones) from childhood to present: __Yes __No
When: _____
_____

Falls/Injuries (including sports) from childhood to present: __Yes __No
When: _____
_____

Surgeries/Hospitalization: _____
_____

Medications/Supplements (prescription/over-the-counter/birth control): __Yes __No
What: _____
_____

On a scale of 1-10 describe your stress level (1 = none, 10 = extreme):
Occupational: _____ Personal: _____

On a scale of poor, good, and excellent, describe the following:
Diet: _____ Exercise: _____ Sleep: _____ General Health: _____

X-Ray Release:
X-rays may be necessary for a complete diagnosis. This is a safe procedure, however, there is a low risk of radiation exposure. Our office does everything we can to keep your risk at a minimum. If you have any questions or concerns, please tell the doctor.
If you are pregnant or could be pregnant please advise your doctor, Even low doses of radiation could be harmful to your unborn child.

The statements made on this form are accurate to the best of my recollection, and I agree to allow this office to examine me for further evaluation.

_____ _____
Signature **Date**

FINANCIAL AGREEMENT
HEALTH INSURANCE

We would like to take a moment to welcome you to our office and to assure you that you will receive the very best care available for your condition. In order to familiarize you with the financial policy of this office, we would like to explain how your medical bills will be handled.

EXPLANATION OF INSURANCE COVERAGE

Most insurance policies cover Chiropractic care, but this office makes no representation that your does. Insurance policies can differ greatly in terms of deductible and percentage of coverage for Chiropractic care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance company(ies) in a timely manner.

PAYMENT ARRANGEMENTS

We require that you pay _____% or _____ co-pay of your charges on the day the services are performed. Any unpaid balance will be considered past due.

ASSIGNMENT OF BENEFITS

Attached is an "Assignment of Benefits" form which we would like you to sign. This form instructs your insurance company to send their payments directly to this office. Please sign all copies of this form. If your insurance carrier sends you payment for services incurred in this office, you shall send or bring the full payment to our office immediately upon receipt.

RELEASE OF INFORMATION

If your insurance company requires medical reports to document your treatment and progress, your signature below authorizes the release of medical information necessary to process your claim.

VOLUNTARY TERMINATION OF CARE

If you suspend or terminate your care at any time, your portion of all charges for professional services are immediately due and payable to this office. All services rendered by this office are charged directly to you, and you, ultimately, will be personally responsible for payment, regardless of your insurance coverage.

We hope that this answers any questions you might have concerning the financial policies of this office. Once again, we welcome you to our office, and will be glad to answer any further questions that you might have.

I have read and agree to the above.

_____ _____

Patient's Signature Date

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____

Claim or Group # _____

SS# or ID# _____

I hereby instruct the above named insurance company to pay by check made out to and mailed directly to:

Kirwan Chripractic
P.O. Box 1538
Allen, TX 75013

If my current policy prohibits direct payment to the doctor, then I hereby instruct and direct you to make out the check to me and mail it as follows:

C/O

Kirwan Chiropractic
P.O. Box 1538
Allen, TX 75013

for professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance.

Date at _____ County, this ____ day of _____ 20_____.

_____ _____

Signature of Policy Holder Witness

_____

Signature of Claimant, if other than Policyholder

OUR OFFICE POLICY
REGARDING INSURANCE ASSIGNMENT

Our office is pleased to accept your insurance assignment, as soon as your exact coverage is verified by the responsible party. We will supply you with an insurance verification form. We will file your claim and assist you in every way we can.

However, it must be fully understood that the contract is between you and your insurance company and you are fully responsible for any amount not paid by your insurance.

Office Policy Regarding Insurance Assignment:

- Since by taking your insurance on assignment, we have to wait for payment, this courtesy may be withdrawn if circumstances warrant it.

- Your insurance should pay within 30 days. <u>If your insurance has not paid within 60 days, you will be held responsible for paying.</u> *If your insurance company does pay and you have a credit balance, it will be refunded to you.*

- You may pay the percentage of service rendered as you go along. (e.g. if your insurance pays 80% of your care, you may pay 20% on each visit) after meeting your deductible.

- We will bill your insurance bi-monthly as long as you are receiving chiropractic care in this office. **We will need a completed health insurance form from your company.**

- You are required to sign an "Authorization to Pay Physician" form and any other assignment documents required by your insurance company on your first office visit.

- Our office does **NOT** guarantee that your insurance will pay. We will make every attempt, at the beginning of your health care, to receive verification of your policy and what it covers. However, if for some reason your insurance claim is denied, you are responsible for your bill.

- You will receive a monthly statement from this office which will include what your insurance hasn't paid and also what is owed by you.

- If you understand and agree with all of the above office policies, please sign your name below and we will accept your insurance assignment.

- If you have any questions, please feel free to ask.

_____ _____

DATE **SIGNATURE**

FINANCIAL AGREEMENT
CASH PAYMENT

We would like to take a moment to welcome you to our office and to assure you that you will be receiving the very best care available for your condition. To familiarize you with the financial policy of our office, I would like to explain how your medical bills will be handled.

Payment Arrangements:
It is our policy in this office to maintain your account on a current basis. Charges for treatment are due at the time the service is provided. We ask that you make payments on this basis.

If this arrangement becomes inconvenient for you, please see our office manager so that other payment arrangements can be made.

Voluntary Termination of Care:
It is also the policy of this office that if you should choose to suspend or terminate your care and treatment, any outstanding fees for professional services rendered to you will be immediately due and payable.

We hope that this has answered any questions you might have regarding your financial arrangements. Once again, we would like to welcome you to our office. If, at any time, you have any questions about your case, please don't hesitate to ask.

I have read and agree to the above.

_____ _____

Patient's Signature **Date**

CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize Dr. _____ and whomever he or she may designate as his/her assistants to administer chiropractic care and diagnostic testing as he/she deems necessary to my _____.

_____ (name of child)

Dated at _____ (city) _____ (state)

this _____ day of _____, 20 _____.

Signed: _____
(Parent or Guardian)

Witness: _____

Mary Ellen Kirwan, D.C.
Chiropractic Physician

Kirwan Chiropractic Centre
4708 W. Plano Pkwy, Ste. 300
Plano, Texas 75093
972-265-8100

Kirwan Chiropractic
Notice of Privacy Practices

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

The Practice (the "Practice"), in accordance with the Federal Privacy Rule, 45 CFR parts 160 and 164 (the "Privacy Rule") and applicable state law, is committed to maintaining the privacy of your protected health information ("PHI"). PHI includes information about your health condition and the care and treatment you receive from the Practice and is often referred to as your health care or medical record. This Notice explains how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI.

HOW THE PRACTICE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The Practice, in accordance with this Notice and without asking for your express consent or authorization, may use and disclose your PHI for the purpose of:

(a) Treatment – To provide you with the health care you require, the Practice may use and disclose your PHI to those health care professionals, whether on the Practice's staff or not, so that it may provide, coordinate, plan and manage your health care. For example, a chiropractor treating you for lower back pain may need to know and obtain the results of your latest physician examination or last treatment plan.

(b) Payment – To get paid for services provided to you, the Practice may provide your PHI, directly or through a billing service, to a third party who may be responsible for your care, including insurance companies and health plans. If necessary, the Practice may use your PHI in other collection efforts with respect to all persons who may be liable to the Practice for bills related to your care. For example, the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice can be reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.

(c) Health Care Operations – To operate in accordance with applicable law and insurance requirements, and to provide quality and efficient care, the Practice may need to compile, use and disclose your PHI. For example, the Practice may use your PHI to evaluate the performance of the Practice's personnel in providing care to you.

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

YOUR RIGHTS

You have the right to:

(a) Revoke any Authorization or consent you have given to the Practice, at any time. To request a Revocation, you must submit a written request to the Practice's Privacy Officer.

(b) Request special restrictions on certain uses and disclosures of your PHI as authorized by law. In general, this relates to your right to request restrictions concerning disclosures of your PHI regarding uses for treatment, payment and operational purposes under Privacy Rule, Section 164.522(a) and restrictions related to disclosures to your family and other individuals involved in your care under Privacy Rule, Section 164.510(b). Except in certain instances, the Practice may not be obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In

your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.

(c) Receive confidential communications or PHI by alternative means or at alternative locations as provided by Privacy Rule, Section 164.522(b). For instance, you may request all written communications to you marked "Confidential Protected Health Information." You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

Amend your PHI as provided by federal law (including Privacy Rule, Section 164.526) and state law. To request an amendment, you must submit a written request to the Practice's Privacy Officer. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.

(d) Receive an accounting of disclosures of your PHI. The Practice will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred. Complain to the Practice or to the Secretary of HHS if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

It is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.

Will not retaliate against you for filing a complaint.

This Notice is in effect as of 04/15/2003.

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Patient Name: _____

Date: _____