WELCOME!

Form 033022

Patient Information

Date _____ Patient Number_____

Name_____M/F Date of Birth _____SS#_____

Address_____

City_____State____Zip Code_____email_____

Cell_____ Hm. _____ Wk._____ Employer_____

Emergency Contact Name_____Emergency Contact #_____

Name of nearest relative not living with you_____Phone #_____

Responsible Party

Name of person responsible for this account_____

Relationship to patient_____Address_____

Home Phone_____Driver's License # & State issued_____

Date of Birth_____Employer_____Work Phone #_____

SS#_____Is this person a patient at our office?_____

Insurance Information

Name of Insured_____Relationship to patient_____

Date of Birth_____SS#_____Date Employed_____

Name of Employer_____Address_____

City_____State_____Zip Code_____

Payment Responsibility Acknowledgement

I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself. Also, I understand that this chiropractic office may prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for the payment. I completely understand that if I choose to terminate my care and treatment any fees for professional services rendered to me will be immediately due and payable. I understand that if the account is 30 days delinquent, the balance may be sent to collections. Also, I understand and agree to reimburse this office for any and all collection fees, attorney fees, court costs, and filing fees for any reason including the event of default or failure to pay the balance.

Patient's Signature:_____

Informed consent of examination and release of information

I hereby authorize the doctor and whomever he may designate as his assistants to administer treatment, physical examinations, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he deems necessary in my case. I understand that the examination is to include information about myself and my personal circumstances as well as my health. I understand that the examination is not intended to do harm or cause pain. Although the purpose of the examination is to duplicate my complaints and this may cause discomfort or pain. Because of this factor, I should not perform any task beyond what I can normally and physically tolerate. I understand that it is my responsibility to inform the examining physician of my limitations and hesitations. I understand that the results of this evaluation may not be made known to me at the time of the completion of the evaluation. I authorize the doctor and staff to disclose all or any part of my (patient's) record to any person , corporation, or entity which is or may be liable to the clinic or to the patient or to a family member or employer or the patient for all or part of the charges, including, and not limited to hospital, or medical services companies, insurance companies, workers compensation carriers, welfare fund or the patient's employer. I authorize this office to treat my minor child without my presence. I authorize my attorney to disclose all information on my case to this office.

Patient's Signature: _____

DISCLOSURE OF FEE/PAYMENT POLICY

99201-25	**NEW PATIENT MINOR EXAM**	**$80.00**
99202-25	**NEW PATIENT PROBLEM FOCUSED EXAM**	**$175.00**
99203-25	**NEW PATIENT DETAILED HISTORY EXAM**	**$300.00**
99211-25	**EST. PATIENT MINOR EXAM/ OFFICE VISIT**	**$45.00**
99212-25	**EST. PATIENT PROBLEM FOCUSED EXAM**	**$60.00**
99213-25	**EST. PATIENT DETAILED HISTORY EXAM**	**$195.00**
98940	**SPINAL ADJUSTMENT, 1-2 LEVELS**	**$55.00**
98941	**SPINAL ADJUSTMENT, 3-4 LEVELS**	**$59.00**
98942	**SPINAL ADJUSTMENT 5 OR MORE LEVELS**	**$69.00**
98943	**EXTREMITY ADJUSTMENT**	**$39.00**
97012	**INTERSEGMENTAL TRACTION**	**$49.00**
G0283	**ELECTRIC MUSCLE STIMULATION**	**$49.00**
97035	**ULTRASOUND THERAPY**	**$39.00**
97022	**HYDROTHERAPY**	**$59.00**
97026	**INFRARED THERAPY**	**$49.00**
97140-59	**MANUAL THERAPY**	**$58.00**
S9090	**SPINAL DECOMPRESSION**	**$150.00**
A4456	**ELECTRODES**	**$16.00**
99052	**HOLIDAY VISIT**	**$39.00**
99050	**AFTER HOURS VISIT(after 6:30 MTWF)**	**$25.00**
99050	**AFTER HOURS VISIT(days closed Thurs, Sat, Sun)**	**$39.00**
E0730-NU	**TENS UNIT**	**$195.00**
L0631	**LSO SPINAL ORTHOSIS**	**$800.00**
99080	**FMLA/DISABILITY FORMS**	**$25.00**
99080	**CERTIFIED LETTER**	**$15.00**

I have read the above codes and fees and understand the cost of my care Keller Family Chiropractic. I understand that therapies are billed in quarter hour increments. I understand that I am responsible for payment of all deductibles, co-payments, co-insurance, and insurance non-payments related to my care. I understand that this is a partial list of services rendered and subject to change without notice. ***I understand that most insurance policies do not cover spinal decompression.*** I understand that if my insurance does not pay for spinal decompression, a minimum of $50.00 will be transferred to my balance for each spinal decompression session. I understand that if I have a balance for medical services not paid, I will make a minimum payment of $50.00 each month or 25% of the outstanding balance whichever is greater. I understand that I am responsible for verifying my insurance. I understand that I am responsible for requesting a referral from my primary care provider. If my balance is not paid in a timely fashion, I promise to pay any and all collection, court, and attorney fees in the collection of my account. I understand if my insurance company does not pay my bill within 90 days that the original fee schedule applies. I understand that if my account is 30 days delinquent, my balance may be sent to collections. I understand that any transaction on my account including but not limited to charges, payments, collection agency fees, and attorney fees will re-age my account and the statute of limitations will begin on the date of the last transaction. I further understand that if my treatment is associated with personal injury or accident claim, all medical bills will be paid at 100% of the above fee schedule regardless of the outcome of my case and that my claim will not be billed to my health insurance, but may be billed to my PIP coverage or sent to the patients representing attorney. I understand that my balance with KFCA, PA may be sold, transferred, or assigned to another party I understand that all sales on durable medical equipment are final. I understand that if a check or debit is returned for insufficient funds, I will be charged a $35.00 service charge.

I have read and fully understand the above financial terms and prices.

Patient's Signature _____ Date _____

AUTHORIZATION AND ASSIGNMENT

I hereby instruct and direct the _____ Insurance Company to pay by check made out and mailed directly to:

KFCA, PA
PO Box 1243
Keller, TX 76244-1243

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

KFCA, PA
PO Box 1243
Keller, TX 76244-1243

The professional or chiropractic 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 service charges over and above this insurance payment. 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 involved in this case.

Dated at this _____ day of _____

_____ _____
Signature of policyholder Signature of Claimant, if other than policy holder

_____

- With my signature above, the co-payment would be a financial hardship on me.

LETTER OF NO ACCIDENT OR INJURY

I hereby state with my signature that I was not involved in any auto accident, slip and fall, or work injury. My treatment is in no way associated with any 3rd party, and no other party is responsible or liable for the cost of my treatment.

Please process any pay all claims immediately.

_____ _____
Patient's Signature Date

APPOINTMENT CANCELLATION POLICY

I hereby understand with my signature, that if I do not cancel my appointment 24 hours prior to the appointment, I will be charged a no show fee of $60. I understand that I am responsible for this payment and that it is not the responsibility of my insurance company, third party payer, PIP coverage, workers compensation carrier, or my attorney.

_____ _____
Patient's Signature Date

NOTIFICATION OF MY PRIMARY CARE PHYSICIAN (optional)

I request that my initial notes be sent to my primary care physician. My PCP is_____ and the contact phone number is _____

_____ _____
Patient's Signature Date

Keller Family Chiropractic
PO Box 1243
Keller, TX 76244-1243
Ph. (817)431-2210 Fax (888)990-2210

NOTICE OF INFORMED CONSENT

Every type of health care is associated with some risk of a potential problem. This includes chiropractic care. We want you to be informed about the potential problems associated with chiropractic are before consenting to treatment. This is called an informed consent.

A subluxation is a medical term that describes what occurs when one or more of the spinal (vertebral) joints have moved out of its normal alignment. This can occur through recent or remote trauma as well as unusual positions in which we find ourselves throughout the day or night. A subluxation has also has been described as an incomplete dislocation of a joint and as such, it is not treated with drugs or surgery. Chiropractors treat vertebral subluxation with spinal adjustments (performed by hand or with the use of a specific tool) in order to reposition the misaligned segments. Frequently, adjustments create a popping sound or clicking sensation in the area being treated. This sound is the release of gas that has been created by suction in the joint.

In this office we use highly trained staff to assist the doctor with portions of your consultation, examination, x-ray, physiotherapy, traction, massage, exercise instruction, etc. Occasionally, when your doctor is not available another clinic doctor will treat you in his place.

Stroke: Stroke is the most serious problem associated with spinal adjustments, regardless of whether the provider is a chiropractor or medical physician. A stroke occurs when a portion of the brain does not receive enough oxygen from the blood stream. The result can be temporary or permanent dysfunction of the brain, with a much more rare complication of death. Spinal adjustments have been associated with strokes that arise from the vertebral artery. The specific neck adjustment that is related to this complication is not performed in this office. The most recent studies (Journal of the California Chiropractic Association Vol.37, No. 26-93) estimates that the incidence of this type of complication occurring is 1(one) in every 3,000,000 (three million) adjustment to the neck. This means that the average chiropractor would have to practice for over 100 years before they would be statistically associated with a single patient stroke.

The most effective method of lessening the odds that a patient is prone to a stroke is through careful screening of risk factors in the history, including medications taken, as well as a family history of high blood pressure and specific exam procedures to assess blood flow to the brain.

Disc Herniation: Disc herniations that create pressure on nerves or the spinal cord are frequently treated successfully by chiropractors using adjustments, distraction, and other therapies. This includes both in the neck and the low back. Occasionally chiropractic treatment will aggravate this problem. To help prevent this, patients are put through specific range of motion tests and procedures during the examination to see if any of these positions might aggravate disc symptoms. Due to the fact of such careful attention to detail, these complications occur so rarely that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissue refers primarily to the muscles, tendons, and ligaments. Muscles move bones and ligaments limiting joint movement. Rarely, a chiropractic adjustment, traction, massage, etc. may strain some muscle or ligament fibers. The result is a temporary increase in pain requiring specific treatment for resolution, with no long-term affects to the patient. These problems occur so rarely that there is no available statistics to quantify their probability.

Rib Fracture: The ribs are found attached to the thoracic spine in the middle of the back. They extend from your back to the front of your chest. Rarely, a chiropractic adjustment may break a rib, this is referred to as a fracture. This occurs in those patients who have weakened bones form such things as osteoporosis, prolonged steroid use, or other bone weakening diseases. This can be ruled out in the history or x-rays. We adjust all patients carefully and especially those with bone weakened conditions. These problems occur so rarely that there are no available statistics to quantify their probability.

Physical Therapy Irritations: Some therapeutic machines and analgesic balms generate heat. We use different forms of heat and ice in the office and occasionally recommend them for use at home. Everyone's skin has a different sensitivity to these modalities, and rarely heat or ice can irritate the skin. The result is a temporary increase in skin pain and possibly some blistering. These problems occur so rarely that there is no available statistics to quantify their probability.

Soreness: It is not uncommon for spinal adjustments, distraction, massage, exercise, etc. to result in a temporary increase in soreness in the area being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but do tell the doctor or staff member about it.

Other Problems: There may be other problems or complications that may arise from chiropractic treatment other than those mentioned above. These other complications occur so rarely that it is impossible to anticipate or explain them all in advance of treatment.

The Risks and Dangers Attendant to Remaining Untreated: Remaining untreated allows the formation of adhesions and reduces mobility, which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment, making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

Chiropractic is a system of health care delivery, and therefore, as with any health care delivery system, we cannot promised a cure for all symptoms, disease, or conditions as a result of treatment at this facility. We will always give you the best care that we can deliver and if the results are not acceptable, we will gladly discuss other types of treatment options or refer you to another health care provider for alternative types of treatment.

I hereby authorize the doctor(s) or assistants in this office to perform upon my examination and diagnostic procedures arising from current or presently unforeseen conditions. I understand that this office has the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and conduction of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor(s) can determine whether to accept me as a patient.

If you have any questions on the above information, please ask your doctor to explain them more fully. When you have a full understanding of this material, please sign and date this document below and then return it to the front desk or doctor.

_____ _____/_____/_____

Patient's Signature Date

_____ _____

Patient's Name Parent/Guardians Signature

_____ _____/_____/_____

Witness Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Communications barrier prohibited obtaining acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____
_____
_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 12/01/08, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or disclose it to anyone for any purpose if you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification, of (including identifying or locating) a family member, your present representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use or disclose your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you the amount allowed under the Texas Administrative Code, Title 22, part 3 chapter 80, rule 80.3. If you request an alternative format we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities for the last 6 years but not before December 1, 2008. If you request this accounting more than once a 12 month period we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be n writing and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices, or have questions or concerns, please contact us. If you are concerns that we have violated your privacy rights or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosures of your health information or to have us communicate with you by alternative means or at alternative locations you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you chose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer Ronald Faries, D.C.
Telephone 817-431-2210
Address PO Box 1243
Keller, TX 76244-1243