CHIROPRACTIC CASE HISTORY

CONFIDENTIAL PATIENT INFORMATION DATE _____

Name _____ SS# ☐☐☐ ☐☐ ☐☐☐☐

Home Phone ( )____-_____ Cell Phone ( )____-_____ E-mail

Address _____ City _____ State _____ Zip _____

Age _____ Gender: M F Birth Date _____ Marital: M S D W How Many Children? _____

Occupation _____ Employer _____

Address _____ Office Phone _____

Are you a student? Y N Part – Time / Full – Time (circle one) School _____

Name of Husband or Wife _____ Occupation _____

Employer _____ Phone _____

Name of Nearest Relative _____ Phone _____

Emergecy Contact _____ Phone _____

Referred by _____

Is the condition due to injury or sickness arising out of employment? _____ Auto or Other Accident? _____

Days lost from work? _____ Date symptoms appeared or accident happened? _____

Have you ever had the same or similar condition? Yes _____ No _____ If yes, when and describe _____

_____

Name of family physician _____ May we contact? Yes No

Date of last physical exam _____ What operations or serious illnesses have you had and when? _____

_____

Have you ever suffered from: (check all that apply)

1. Dizziness _____
2. Backaches _____
3. Heart Trouble _____
4. Diabetes _____
5. Hernia _____
6. Arthritis _____
7. Headaches _____
8. Numbness _____
9. Asthma _____
10. Neuritis _____
11. Digestive Disorders _____
12. Nervousness _____
13. Sinus Trouble _____
14. Anemia _____
15. Rheumatic Fever _____
16. Cancer _____

Purpose of this appointment _____

Other doctors seen for this condition _____

Has a physician treated you for any health condition in the last year? Y N Describe _____

_____

What medications or drugs are you taking? _____

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself -- not between my insurance company and this office. I authorize this chiropractic clinic to release any medical information and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance company.
If mine is a regular health insurance case, I agree to pay a percentage of services as they are rendered. However, I understand that I am ultimately responsible for payment in full at this office. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

HEALTH INSURANCE YES ☐ NO ☐ COMPANY _____

Insured's Name(PRINT) _____ Date of Birth _____

PATIENT'S SIGNATURE (or guardian) _____ Date _____

FINANCIAL POLICY

For the convenience of our patients, the following are stated as a guide to financial arrangements. Please ask for a full explanation of any charges that you do not understand.

METHODS OF PAYMENT Please check one of the following.

_____ A. Cash. Payment is expected in full as treatment is performed.

_____ B. Health Insurance. Your co-pay is to be paid in full as services are performed. If you have chiropractic coverage, we will cooperate in every reasonable manner. However, you must understand that your bill is your own personal responsibility. If your deductible has not been met, services are to be paid in full at the time of service. Certain plans have a maximum visit limit per year, once that limit is met, you will be switched over to a cash patient and services will need to be paid in full at the time of visit.

_____ C. Medicare. We are a participating provider, meaning we will bill Medicare first and then bill any remaining co-pay to a secondary insurance if you have one. Medicare insurance only covers the spinal manipulation. They do not cover any x-rays, examinations or therapy (such as electrical muscle stimulation or ultrasound therapy). Most of the time when Medicare denies payment for a service the secondary insurance will deny payment also.

_____ D. Auto Accident/Personal Injury. Please present *your* personal auto insurance information to the receptionist. No 3rd party insurance will be accepted after you leave our office. You need to make a claim at *your* insurance agency and then inform us of the claim #, address and phone number. We will bill your insurance company weekly and will send you a statement at the end of care. Please remember you are responsible for your bill. All fees are due at the time of service.

_____ E. Worker's Compensation pays in full for chiropractic care as long as your company authorizes treatment in our office. Upon being released from care, a 3-month time period is allowed for settlement of your claim. If settlement has not been reached within this time period, or if you have suspended or terminated your care without your doctor's approval, payment for services is due immediately.

Service Charge

If I do not pay the entire new balance within 30 days of the monthly billing date, a service charge will be added to the account for the current billing period. The service charge will be a periodic rate of 1.5% per month, (or a minimum charge of $5.00 for a balance under $1.00.), which is an annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of thus account or future outstanding accounts.

_____ _____

Patient's Signature (or guardian) Date

HIPAA Notice of Privacy Practices

Dunham-Fritz Chiropractic
2501 South Center Street, Suite E
Marshalltown, IA 50158
(641) 752-3112 / (641) 753-4716

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature_____

Date_____