

Pt # _____ ***** **PATIENT UPDATE** ***** date: _____

Name: _____ Date Birth ____ / ____ / ____ Sex: M F

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

Phones: cell - _____ home - _____ work - _____

Married / Divorced / Widow / Single ** Spouse's name: _____

Employer: _____ Phone: _____ Full-time / Part-time

Describe your complaint / symptoms: _____

When did your condition begin? _____

How did it start? sudden / gradual / unknown / fall / accident / chronic / _____

Are these the same symptoms we saw you for last time? Yes No Don't remember

Are your symptoms constant? Yes No *** Have they gotten worse? Yes No

Do you have? Numbness - Yes No ** Tingling - Yes No ** Loss of any strength - Yes No ** Pain in arms / legs Yes No

Have you seen anyone else for these symptoms? Yes No ** If Yes who? _____

Have you been in an accident or had a fall since we last saw you on _____ Yes No

On a scale of 0-10 (0 - no pain / 5 - mild pain / 10 - severe pain) what is your pain level today? _____

Are you on any over the counter medication? Yes No **** if yes what? _____

Are you on any prescription medication for ANY condition? Yes No **** If yes what? _____

**** Since we last saw you on _____ have you had any surgery? Yes No

have you had any broken bones? Yes No

have you been diagnosed with any health problems? Yes No

I attest that my answers are correct and truthful

SIGNATURE: _____ DATE: _____

FOR OFFICE USE: ***** Dr. Initials _____ date: ____ / ____ / ____

McMullen Chiropractic Clinic Financial Policy

If we haven't been able to verify your insurance at the time of your visit you will have to pay your charges in full. If you have any questions about this please ask before the doctor sees you.

Payment for your first day services are due in full at the time they are rendered. This may include charges for examination, x-rays and treatment. We accept cash, checks, MasterCard and Visa. Following your examination, we will discuss your charges with you. If you have insurance, we will verify your benefits so long as you provide us with a copy of your insurance card or provide the information verbally to us. We must have a policy or group number and a phone number to call for verification. Upon obtaining the insurance company address, we will bill the insurance weekly for your charges. You will receive a monthly statement showing any activity and/or payment(s) on your account.

You must realize however, that:

1. We will require payment upon each visit until your deductible is met.
2. Once your deductible has been satisfied, we will expect payment of your co-pay/co-insurance at each visit.
3. Not all services are a "covered benefit" in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. We must emphasize that as health care providers, our relationship is with you, not your insurance company. While the filing of insurance is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

We realize that temporarily financial problems may affect timely payment of your account. If such problem do arise, we ask you to contact us immediately so we may assist in the management of your account.

If you have any questions about payment policies or regarding your INSURANCE COVERAGE, please don't hesitate to ask. If you do not have insurance please advise the receptionist at once so that we may discuss our payment policies in your situation in advance.

SHOULD WE HAVE TO TURN YOUR ACCOUNT OVER TO A COLLECTION AGENCY YOU WILL BE RESPONSIBLE FOR ALL COLLECTION FEES THAT ARE CHARGED BY THE COLLECTION AGENCY.

***** NSF CHECKS ARE CHARGED A \$30 FEE AND MUST BE PAID WITHIN 10 DAYS OF NOTICE.**

MCMULLEN CHIROPRACTIC INFORMATION PRACTICES

The Health Insurance Portability and Accountability Act gives patients "a right to a notice as to the uses and disclosures of protected health information" as well as the individual's rights and the covered entity's legal duties with respect to protected health information.

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

- I. Types of uses and disclosures our clinic is allowed to make:
 - a. to an insurance company for filing your charges
 - b. to your representative with a signed authorization
 - c. to another doctor with a signed authorization
- II. You may have access to you records with written notice and upon paying \$.75 a page. Payment for copies of records must be made in advance. Copies will be available within 5 business days of your written request. X-rays will be sent to a healthcare provider upon written request
- III. We do not fax medical records but send them either US mail or Fed Ex.
- IV. Do you have any questions regarding our safeguards with your health information? Yes / No
- V. Should we need to send correspondence to you we will send it to your home address unless you inform us in writing not to do so.

Patient Signature

Date