

STUDENT ENTRANCE RECORD: Please print or write legibly as we need all the facts about your health before we accept you as a patient. Your information will be kept confidential.

Name: _____ Birth date: _____ / _____ / _____ Sex: M / F **Date:** _____

Parent or Guardian - if patient is a minor; _____ Relationship: _____

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

Parent's name(s): _____

Phone Numbers: your cell _____ Parent's cell _____

Where do you attend school? _____ Are you a Fr / Soph / Jr / Senior / Grad Std

Do you work? yes no If yes where? _____

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

Previous Chiropractic: Yes / No *** Where: _____ When: _____

Family doctor: _____ Which clinic/office? _____

EMERGENCY CONTACT: name _____ phone number: _____

Social Security number: _____ **Signature:** _____

Present complaint/symptom(s) _____

When did your symptoms start? **(If filing insurance we must have a specific date)** _____

How did they start? _____

Have you seen anyone else for your symptoms? YES / NO *** If yes who and when: _____

List any operations you have had and when: NONE / _____

List any broken / fractured bones: NONE / _____

Are you presently taking ANY prescription medication? YES / NO

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