MCKENZIE
CHIROPRACTIC CLINIC

Patient #: _____
Date : _____
Doctor: _____

## PATIENT INFORMATION

First Name: _____ Last Name: _____

Birth Date: _____ Age: _____

Address: _____

City: _____ State: _____

Email: _____ Cell Phone: _____ ZIP _____

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Other _____

Occupation: _____ Employer: _____

Employer Address: _____ Employer Phone: _____

Name of Nearest Relative: _____ Address: _____

Relative's Phone #: _____

## INSURANCE INFORMATION

Please check all insurance coverage that may be applicable in this case:

◯ Major Medical ◯ Worker's Compensation ◯ Other _____

◯ Medicare ◯ Auto Accident

Name of Insurance Company: _____ State: _____

Policy Holder Name: _____ Birth Date: _____

Member ID: _____ Group: _____

Name of Employer: _____

Relationship to Insurance holder: ◯ Self ◯ Parent ◯ Child ◯ Spouse ◯ Other _____

Name of Secondary Insurance Company: _____ State: _____

Policy Holder Name: _____ Birth Date: _____

Member ID: _____ Group: _____

Name of Employer: _____

Relationship to Insurance holder: ◯ Self ◯ Parent ◯ Child ◯ Spouse ◯ Other _____

AUTHORIZE AND RELEASE: I authorize payment of insurance benefit directly to the chiropractor or chiropractic office. I authorize the doctor to release/obtain all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all cost of chiropractic care regardless of insurance coverage. I promise to notify McKenzie Chiropractic Clinic if at any time there is a change in my Insurance Policy(s) or Benefits. I expressly guarantee payment of the account/dependent named above and agree to pay any charges left unpaid in whole or in part by the insurance company. 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. I understand that interest is charged on overdue accounts at the annual rate of 18%. Cash-Based Treatment Package sales are final and no refunds will be issued. I understand packages do not expire and can only be redeemed at the original location of purchase and that any unused sessions are transferable to family/friends.

The patient understands and agrees to allow this chiropractic office to use their Protected Health Information ("PHI") for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your PHI is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

_____ _____
Patient Signature Date

_____ _____
Guardian's Signature Authorizing Care Date

MCKENZIE
CHIROPRACTIC CLINIC

Patient #: _____
Date : _____
Doctor: _____

## HEALTH INFORMATION

How were you referred to our office? _____

Family Medical Doctor: _____ Phone: _____

Date of last physical examination: _____ Date symptoms appeared: _____

Purpose of this Appointment: _____

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

_____

Medications: _____

_____

Serious illnesses / surgeries (include dates): _____

_____

Have you been treated for any health condition by a physician in the last year? Yes: _____ No: _____

If yes, please describe: _____

---

What is your major symptom? _____

What does this prevent you from doing or enjoying? _____

_____

If this is a recurrence, when was the first time you noticed this problem? _____

How did it originally occur? _____

Please Describe: _____

Has it become worse recently? Yes_____ No_____Same _____ Better_____Gradually Worse _____

How frequent is the condition? Constant _____Daily _____ Intermittent_____ Night Only_____
How long does it last? All Day _____ Few Hours _____ Minutes _____

Are there any other conditions or symptoms that may be related to you major symptom? Yes _____ No _____

If yes, describe: _____

Describe the pain: Sharp____ Dull____Numbness____Tingling____Aching____Burning ____Stabbing____ Other: ____
What makes the problem worse: Standing _____ Sitting ____ Lying _____ Bending _____ Lifting _____Twisting_____

Other, Please Describe: _____

Is there anything that you can do to relieve the problem: Medication _____ Stretching _____ Exercise ____
Laying _____ Resting _____ Sitting _____ Cold _____ Heat _____ Massage _____

What have you tried that has not helped? _____

Have you had any broken bones? Yes _____ No _____ If yes, please list and explain: _____

_____

Do you exercise? Yes ____ No ____ If yes, what forms: _____

**Women Only:** Are you pregnant or is there any possibility you may be pregnant? Yes ____ No ____ Uncertain_____

Remarks: _____

_____

**Please Indicate Your Pain Level Below**

**No Pain 1 2 3 4 5 6 7 8 9 10 Severe Pain**

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# FINANCIAL POLICY AND AGREEMENT

1. **Financial Responsibility Policy**

By receiving care at McKenzie Chiropractic, you agree to the following financial responsibilities:

- You are financially responsible for all services rendered, regardless of insurance coverage.
- Payment is due at the time of service unless other arrangements are made in writing.
- Balances over $75 must be addressed promptly. Late payments may incur a charge of 1.5% per month (18% annually), or the maximum allowed by law.
- Prepaid packages do not expire. Pro-rata refunds will be provided if treatment becomes clinically inappropriate, the clinic relocates or closes, or the patient relocates more than 25 miles.
- If care ends, you owe only for services already rendered.
- Accounts sent to collections may include actual third-party costs if permitted by law.

2. **Insurance Assignment; Authorized Representative Policy**

If you choose to have us bill your insurance, you agree to the following:

- You assign insurance benefits directly to this clinic for services provided.
- You appoint the clinic as your Authorized Representative for claims and appeals, to the extent permitted by law.
- You remain responsible for deductibles, co-pays, co-insurance, and amounts not covered by insurance.
- If your insurer does not pay within 120 days, you will assist in recovery efforts. After 150 days, you are responsible for the balance.
- If care ends, you only owe for services rendered, and insurance assignment ends.

3. **Cash (self-pay) Payment Election Options**

This policy outlines the legally compliant methods for offering reduced rates to patients, while ensuring alignment with insurance contracts, federal/state regulations, and ethical billing practices.

_____ _____

Patient Signature Date

_____ _____

Guardian's Signature Authorizing Care Date

MCKENZIE
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# Cash Payment Amendment to Financial Responsibility and Payment Agreement

This policy outlines the legally compliant methods for offering reduced rates to patients, while ensuring alignment with insurance contracts, federal/state regulations, and ethical billing practices.

Cash Payment Election Options: Please select one of the following payment options:

## Option 1: Standard Cash Pay Rate

I elect to pay for care using the clinic's published cash pay rate at a 15% discount. I understand this rate is fixed and I am choosing not to submit any claims to my insurance.

□ I elect Option 1: Standard Cash Pay Rate with 15% discount

## Option 2: Prompt Pay Discount

I elect to receive a prompt pay 24% discount for paying my entire balance on the day of service. I understand that this discount is only available when no insurance claim is submitted.

□ I elect Option 2: Prompt Pay Discount 24% discount

## Option 3: Financial Hardship Discount

I am requesting a discount due to financial hardship. I understand that I must complete a hardship application and provide documentation upon request. Discounts are subject to approval and review.

□ I elect Option 3: Financial Hardship Discount; need based discount

Date of hardship application submission (if applicable): _____

Acknowledgment Signature

By signing below, I acknowledge and agree to the policies and options I have selected above.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

Staff Witness (if applicable): _____ Date: _____

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# Informed Consent for the Chiropractic Patient:

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

**The nature of the chiropractic adjustment:**
The primary treatment used by doctors of chiropractic is spinal manipulative therapy. The doctors will use this procedure to treat you. We may use our hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

**Analysis / Examination / Treatment:**
As a part of the analysis, examination, and treatment, you are consenting the following procedures: vital signs, spinal and extremity manipulative therapy, palpation, radiographic studies, range of motion testing, orthopedic testing, basic neurological testing, muscle strength testing, postural analysis testing, massage therapy, traction, and/or hot & cold therapy.

**The risks inherent in chiropractic adjustment:**
It is common to feel stiffness or soreness following the first few days of treatment. As with any other healthcare procedure, there are certain rare complications which may arise during chiropractic manipulation and therapy such as minor muscle pulls or fractures. Fractures are very rare occurrence and generally a result from some underlying weakness of the bone. Stroke and /or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to any specific incident of this complication occurring. The doctor will make every reasonable effort during the examination to screen for contraindications to care, however if you have a condition that would not come to the Doctor's obvious attention, it is your responsibility to inform the doctor.

**The risks and dangers attendant to remaining untreated:**
Remaining untreated may allow the formation of adhesions and reduce mobility which may set 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 availability and nature of other treatment options:**
Other treatment options for your condition may include:
- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE: I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have had all my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. I hereby give my consent to chiropractic treatment and authorize any pertinent medical records exchange. I understand this consent to be effective until I am notified otherwise.

Patient's Name:_____ Signature:_____ Dated: _____

**CONSENT TO TREATMENT (MINOR)**

As the Parent or Guardian, I hereby request and authorize McKenzie Chiropractic Clinic to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter: This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named below. And, if applicable, under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Parent/Guardian's Name:_____ Child's Name:_____

Signature of Parent/Guardian: _____ Date: _____

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# Protected Health Information Consent Form

We want you to know how your Protected Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. HIPAA NOTICE OF PRIVACY PRACTICES is a more detailed account of our policies and procedures is available to you at any time and we encourage you to read the notice before signing this consent.

The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

The patient has the right to examine or obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to these restrictions.

A patient's written consent need only be obtained one time for all subsequent care given at this office.

The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent, but would apply to any care given after the request has been presented.

For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my PHI will be used and I agree to use these policies and procedures.

_____ _____

Patient Signature Date

# MCKENZIE CHIROPRACTIC CLINIC HIPAA NOTICE OF PRIVACY PRACTICES

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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

## Overview

The law requires us to keep your protected health information ("PHI") private in accordance with this Notice of Privacy Practices ("Notice"), as long as this Notice remains in effect. We are also required to provide you with a paper copy of this Notice, which contains our privacy practices, our legal duties, and your rights concerning your PHI. From time to time, we may revise our privacy practices and the terms of our Notice at any time, as permitted or required by applicable law. Such revisions to our privacy practices and our Notice may be retroactive. Our Notice will be updated and made available to our patients prior to any significant revisions of our privacy practices and policies.

## Our Privacy Practices

Use and Disclosure. We may use or disclose your PHI for treatment, payment, or health care operations. For your convenience, we have provided the following examples of such potential uses or disclosures:

**Treatment:** Your PHI may be used by or disclosed to any physicians or other health care providers involved with the medical services provided to you.

**Payment:** Your PHI may be used or disclosed in order to collect payment for the medical services provided to you.

**Health Care Operations:** Your PHI may be used or disclosed as part of our internal health care operations. Such health care operations may include, among other things, quality of care audits of our staff and affiliates, conducting training programs, accreditation, certification, licensing, or credentialing activities. The use of sign-in sheets in which you sign in and out, as identified by HIPAA privacy regulations, does not constitute violation of your PHI.

Authorizations. We will not use or disclose your medical information for any reason except those described in this Notice, unless you provide us with a written authorization to do so. We may request such an authorization to use or disclose your PHI for any purpose, but you are not required to give us such authorization as a condition of your treatment. Any written authorization from you may be revoked by you in writing at any time, but such revocation will not affect any prior authorized uses or disclosures.

Patient Access. We will provide you with access to your PHI, as described below in the Individual Rights section of this Notice. With your permission, or in some emergencies, we may disclose your PHI to your family members, friends, or other people to aid in your treatment or the collection of payment. A disclosure of your PHI may also be made if we determine it is reasonably necessary or in your best interests for such purposes as allowing a person acting on your behalf to receive filled prescriptions, medical supplies, X rays, etc..

Locating Responsible Parties. Your PHI may be disclosed in order to locate, identify or notify a family member, your personal representative, or other person responsible for your care. If we determine in our reasonable professional judgment that you are capable of doing so, you will be given the opportunity to consent to or to prohibit or restrict the extent or recipients of such disclosure. If we determine that you are unable to provide such consent, we will limit the PHI disclosed to the minimum necessary.

Continuing Care. Based upon your PHI, we may provide you with appointment reminders or information concerning health issues, benefits and services, or treatment alternatives that we believe may be of interest to you. Appointment reminders can include phone messages indicating applicable appointment information or appointment change requests.

Disasters. We may use or disclose your PHI to any public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Required by Law. We may use or disclose your medical information when we are required to do so by law. For example, your PHI may be released when required by privacy laws, workers' compensation or similar laws, public health laws, court or administrative orders, subpoenas, certain discovery requests, or other laws, regulations or legal processes.

Under certain circumstances, we may make limited disclosures of PHI directly to law enforcement officials or correctional institutions regarding an inmate, lawful detainee, suspect, fugitive, material witness, missing person, or a victim or suspected victim of abuse, neglect, domestic violence or other crimes. We may disclose your PHI to the extent reasonably necessary to avert a serious threat to your health or safety of the health or safety of others. We may disclose your PHI when necessary to assist law enforcement officials to capture a third party who has admitted to a crime against you or who has escaped from lawful custody.

Deceased Persons. After your death, we may disclose your PHI to a coroner, medical examiner, funeral director, or organ procurement organization in limited circumstances.

Research. Your PHI may also be used or disclosed for research purposes only in those limited circumstances not requiring your written authorization, such as those which have been approved by an institutional review board that has established procedures for ensuring the privacy of your PHI.

Military and National Security. We may disclose to military authorities the medical information of Armed Forces personnel under certain circumstances. When required by law, we may disclose your PHI for intelligence, counterintelligence, and other national security activities.

**Your Individual Rights**

Access and Copies. In most cases, you have the right to review or to purchase copies of your PHI by requesting access or copies in writing to our office. Please contact our office regarding our copying fees.

Disclosure Accounting. You have the right to receive an accounting of the instances, if any, in which your PHI was disclosed for purposes other than those described in the following sections above: Use and Disclosures, Facility Directories, Patient Access, and Locating Responsible Parties. For each 12-month period, you have the right to receive one free copy of an accounting certain details surrounding such disclosures that occurred after April 13, 2003. If you request a disclosure accounting more than once in a 12-month period, we will charge you a reasonable, cost-based fee for each additional request. Please contact our Privacy Officer regarding these fees.

Additional Restrictions. You have the right to request that we place additional restrictions on our use or disclosure of your PHI, but we are not required to honor such a request. We will be bound by such restrictions only if we agree to do so in writing signed by our Privacy Officer.

Alternate Communications. You have the right to request that we communicate with you about your PHI by alternative means or in alternative locations. We will accommodate any reasonable request if it specifies in writing the alternative means or location and provides a satisfactory explanation of how future payments will be handled.

Amendments to PHI. You have the right to request that we amend your PHI. Any such request must be in writing and contain a detailed explanation for the requested amendment. Under certain circumstances, we may deny your request but will provide you a written explanation of the denial. You have the right to send us a statement of disagreement to which we may prepare a rebuttal, a copy of which will be provided to you at no cost. Please contact our Privacy Officer with any further questions about amending your medical record.

Complaints. If you believe we have violated your privacy rights, you may complain to us or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with us by notifying our Privacy Officer. We support your right to protect the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

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