Accelerated Chiropractic & Natural Healing Center, LLC

Randy Hamling, D.C
717 Atlantic Ave.
Morris, MN 56267
(320) 585-7246
acceleratedchiro@gmail.com

# Patient Information

**(* Denotes Required Fields )**

*Name:_____ (Last Name), _____ (Legal First Name) (_____) (Preferred First Name) _____ (MI) *Social Security #_____ *Birth Date:__/__/____ (MM DD YYYY)

*Gender: ❑ Male ❑ Female *Marital: ❑ Married ❑ Single ❑ Widowed ❑ Divorced

*Race: ❑ Caucasian/White ❑ African-American/Black ❑ Asian ❑ Central/South American ❑ Native American ❑ Pacific Islander

*Ethnicity ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I Decline to Answer

*Mailing Address:_____ *City:_____ *State:_____ *Zip:_____

*Home Phone:_____ *Cell Phone:_____ *E-mail address:_____

*Occupation:_____ *Employer:_____

*Employer's Address:_____ *City, State, ZIP:_____ *Office Phone:_____

*Family Medical Doctor:_____ *Medical Facility:_____

*In Case of Emergency, who should we contact?_____ *Phone #:_____

*How would you like to receive appointment reminders? ❑ Text Msg. (*Cell Carrier_____) ❑ E-mail ❑ Text No Appointment Reminders

*Smoking Status: ❑ Every Day Smoker (#years___) ❑ Former Smoker (#years___) ❑ Occasional Smoker (#years___) ❑ Never Smoker

| Current Medications ❑ None | Dosage and Frequency (i.e. 5mg once a day, etc) |
|---|---|
| | |
| | |
| | |
| **Medication Allergies ❑ None** | **Reaction** |
| | |
| | |

*Clinical Summary - We have to make available to you a list of your diagnoses, medications, and medication allergies which can be automatically e-mailed to you following each visit.

❑ I DO want to receive this (E-mail_____) ❑ I DO NOT want to receive this Clinical Summary

*How did you hear about us? (Check all that apply)

❑ Family Member/Friend/Doctor (Who May We Thank?_____)
❑ Fair/Event ❑ Lecture/Business Appreciation
❑ Our Website ❑ Facebook ❑ Clinic Sign/Driving By
❑ White Pages ❑ Yellow Pages
❑ Online Directory (Which Directory?_____)
❑ Other_____

If you are completing this form in office and we make a copy of your insurance card, this insurance information is NOT required.

*Are you the policy holder for your insurance coverage? ❑ Yes ❑ No (If you answered "No" complete information below)

Policy Holder's Name:_____ Relationship to Policy Holder:_____

Policy Holder's Birth Date:__/__/____ Occupation:_____ Employer:_____

Insurance Company:_____ Policy ID#:_____ Group ID#:_____

*Patient's Signature:_____ *Date:__/__/____ (MM DD YYYY)

Guardian's Signature Authorizing Care:_____ *Date:__/__/____ (MM DD YYYY)

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# CONSENT FOR TREATMENT, THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PURPOSES OF BILLING, TREATMENT AND FILE MAINTENANCE

NAME_____, _____

**Purpose of Consent**: By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and health care operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether or not to sign this consent. Our Notice provides a description of our treatment, payment activities and health care operations of the uses and disclosures we may make of you protected health information and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before you sign this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices we will issue a revised Notice of Privacy Practices which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

**Right to Revoke**: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to our Contact Person. Please understand that revocations of this consent will not affect any action we took in reliance on this consent before we received your revocations and that we may decline to treat you or to continue treating you if you revoke this consent.

**Informed Consent:** I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or "Spinal Adjustment". As the joints in your spine are moved you may experience a 'pop' call cavitation as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also know as Oculosympathetic Palsy), costovertebral strains and separations. Rare complications include, but are not limited to stroke. The most common complication or complaint following a spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications and in order to minimize their occurrence I will take precautions. These precautions include but are not limited to my taking a detailed clinical history of you and examining you for any defect which could cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take your clinical history.

I have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that by signing this consent form I am giving my consent to your use and disclosure of my protected health care information to carry out treatment, payment activities and health care operations.

Signature _____ Date_____/_____/_____

If this consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name _____

Relationship to Patient _____

**You are entitled to a copy of this consent after you sign it**

# Authorization and Assignment of Benefits/Financial Policy

**ACCELERATED CHIROPRACTIC & NATURAL HEALING CENTER**
717 Atlantic Ave.
Morris, MN 56267
Tel: 320-585-7246 Fax: 320-585-7247

1. I hereby authorize **Accelerated Chiropractic & Natural Healing Center, LLC** to release any and all appropriate information concerning my health condition to any insurance company, adjuster, attorney requesting it in order to process any claim for re-imbursement of charges incurred by me.

2. This office agrees to assist me in determining what Chiropractic benefits are available under my insurance policy.

3. I understand the benefits quoted to **Accelerated Chiropractic & Natural Healing Center, LLC** by my insurance company are **NOT** a guarantee of payment. This is done by **Accelerated Chiropractic & Natural Healing Center, LLC** as a courtesy and is ultimately my responsibility to know, or find out, what my specific policy covers at this clinic.

4. This office does not file insurance for all secondary carriers, but will support you with paperwork so you can submit your claims.

5. I hereby authorize and assign direct payment to **Accelerated Chiropractic & Natural Healing Center, LLC** for any and all sums owed now or hereafter by any insurance company, which covers the services provided to me by **Accelerated Chiropractic & Natural Healing Center, LLC.**

6. I understand that my insurance carrier most likely does not cover maintenance care. Therefore, once **Accelerated Chiropractic & Natural Healing Center, LLC** informs me that care may be determined to be not Medically necessary, it is my responsibility to pay for such treatments at the time they are rendered or participate in their Pre-Payment Program.

7. I understand that **Accelerated Chiropractic & Natural Healing Center, LLC** does not own my insurance policy and I agree to take an active role in collecting payment from my insurance company. As a courtesy to me, **Accelerated Chiropractic & Natural Healing Center, LLC** will bill my insurance company and wait up to 90 days for payment. If after 90 days my insurance carrier has not paid a claim, I agree to pay for the outstanding charges. I understand **Accelerated Chiropractic & Natural Healing Center, LLC** will send me a payment receipt. Any payments made on these claims thereafter will be refunded to me.

8. I understand and agree to pay a 1.5% monthly (18% annually) service charge on any **outstanding balance** over 90 days old. I understand any and all outstanding balances may be turned over to a collection agency.

9. I understand that **Accelerated Chiropractic & Natural Healing Center, LLC** does not have the capability to securely store credit card information to keep on file. Should I insist they store my credit card information as a convenience to myself, I do not hold **Accelerated Chiropractic & Natural Healing Center, LLC** should this information get misused or lost.

10. I understand that this insurance assignment is offered as a courtesy to me, and may be terminated at any time. I accept full financial responsibility for any and all charges I incur.

11. I agree to pay any and all amounts not paid by the insurance company. If any action must be taken by **Accelerated Chiropractic & Natural Healing Center, LLC** to enforce its rights under this authorization and assignment of benefits, I understand that I may be held responsible for any reasonable costs incurred by taking such action.

**I have read and understand the payment policy of Accelerated Chiropractic & Natural Healing Center, LLC. I understand that deductibles, co-payments, or payments for cash services are due at the time of service or at the end of each week and I agree that my balance will not exceed $150.00 at any time. If I fail to follow any part of this agreement Accelerated Chiropractic & Natural Healing Center, LLC has the right to terminate their professional services and I agree my balance will be due in full at that time.**

MM DD YYYY
/ /

Signature of Patient/Guardian Date

/

Printed Name Last Name First Name MI

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# ACKNOWLEDGEMENT OF NON-CONTRACTUAL SERVICES
# ACKNOWLEDGEMENT OF NON-COVERED SERVICES

I have been advised that my insurance company may deny the services rendered by Accelerated Chiropractic & Natural Healing Center, LLC. Therefore, I acknowledge and accept liability for payment of those services.

Accelerated Chiropractic & Natural Healing Center, LLC, will not be bound to the contractual agreement with my insurance company in regards to non-contractual services. Therefore, I agree to pay the balance due on these services after my insurance company processes the claim. This includes what the insurance company may put in "provider reduction," "contractual agreement," etc.

Some insurance carriers do not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your insurance carrier may not pay for the services and healthcare products below.

| Services | Applicable Insurance Carrier | Reason Insurance May Not Pay: | Cost of Service | Time of Service 30% Discount |
|---|---|---|---|---|
| Initial Exam/Progress Exams | Medicare | Non-covered service | Varies | (-30%) |
| X-Rays | Medicare | Non-covered service | Varies | (-30%) |
| Extremity Adjustment | Medicare, MN Healthcare Programs | Non-covered service / Wellness visit | $30 | $21 |
| Therapeutic Modalities: | | | | |
| - Intersegmental Traction | Medicare, MN Healthcare Programs | Non-covered service / Wellness visit | $25 | $17.50 |
| - Electrical Muscle Stim.- Supervised | Medicare, MN Healthcare Programs | Non-covered service / Wellness visit | $25 | $17.50 |
| - Electrical Muscle Stim.- Attended | Medicare, MN Healthcare Programs | Non-covered service / Wellness visit | $30/$15 | $21 / $10.50 |
| - Ultrasound | Medicare, MN Healthcare Programs | Non-covered service / Wellness visit | $20/$10 | $14 / $7 |
| - Manual Therapy | Medicare, MN Healthcare Programs | Non-covered service / Wellness visit | $40/$20 | $28 / $14 |
| - Strapping | Medicare, MN Healthcare Programs | Non-covered service / Wellness visit | $25 | $17.50 |
| - Pelvic Stabilizers (Shoe Orthotics) | Most Insurance Carriers | Non-contractural service | Varies | No Discount |
| - Supplements/Retail Products | Most Insurance Carriers | Non-contractural service | Varies | No Discount |
| Other: | | | | |

**We do our best to advise you when we recommend a service that will benefit your treatment if that service is covered by your insurance or not. This advisory is to let you know these non-covered services. With this information, it is your responsibility to recognize when a recommended therapy or other non-covered service is about to begin, to advise the doctor if you would choose to decline such a procedure at that time. This is an acknowledgement that you understand the above services are not covered by my insurance and should you choose to still receive the therapy you agree to pay for them the day they are rendered to receive the time of service discount.**

SIGNATURE _____ DATE _____ / _____ / _____
MM DD YYYY

_____
PRINTED NAME