# 21st CENTURY CHIROPRACTIC

10062 W. Fairview Avenue #110, Boise, ID. 83704
www.21stchiro.com
Ph: 208-856-0048 Fx: 833-903-0154

PATIENT: Mr. Mrs. Ms._____ GENDER: M F MARITAL STATUS: M D S W

BIRTH DATE ____/____/_____ AGE: _____ SOC. SEC. NO: _____-_____-_____ EMAIL: _____

PHONE: (HOME) _____-_____-_____ (MOBILE) _____-_____-_____ (BUSINESS): _____-_____-_____

WE CAN REMIND YOU OF APPOINTMENTS BY: _____ TEXT _____ PHONE _____ E-MAIL _____ NONE

MAILING ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PATIENT'S EMPLOYER: _____ OCCUPATION: _____
(parent if a minor)

BUSINESS ADDRESS: _____
(parent if a minor)

NAME OF SPOUSE: _____OCCUPATION: _____

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PLEASE LIST YOUR PARENTS, SPOUSE OR OTHER RELATIVES THAT WE CAN CONTACT IN CASE OF AN EMERGENCY:

1) NAME: _____ RELATION: _____ PH: _____-_____-_____ ADDRESS: _____

2) NAME: _____ RELATION: _____ PH: _____-_____-_____ ADDRESS: _____

REFERRED BY: _____ WHO IS RESPONSIBLE FOR THIS ACCOUNT: _____

NAME OF INSURANCE: _____ FEMALES: ARE YOU PREGNANT? Y / N

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- ◘ Have you ever been to a Chiropractic Physician before? Y / N ◘ If yes, who? _____
- ◘ Date of last Chiropractic visit: _____/_____/_____ ◘ What was wrong? _____
- ◘ Have you been treated for back/neck problems before? Y / N ◘ (If yes, by whom? _____)
- ◘ Who is your medical doctor? _____ ◘ When was your last doctor visit? ____/_____/_____
- ◘ When was your last blood work-up/physical exam? _____/_____/_____ ◘ Was it for this problem? Y / N
- ◘ If yes, what were the results? _____ ◘ Are you on Cholesterol medication? Y / N
- ◘ Please list any medications you are currently taking: 1. _____ 2. _____
- 3. _____ 4. _____ 5. _____ 6. _____
- ◘ Are you diabetic? Y / N ◘ Do you have a pacemaker? Y / N ◘ Have you had a stroke? Y / N ◘ Have you taken Prednisone? Y / N
- ◘ Have you ever been diagnosed with cancer? Y / N ◘ (If yes, what type? _____)
- ◘ What surgeries have you had? _____

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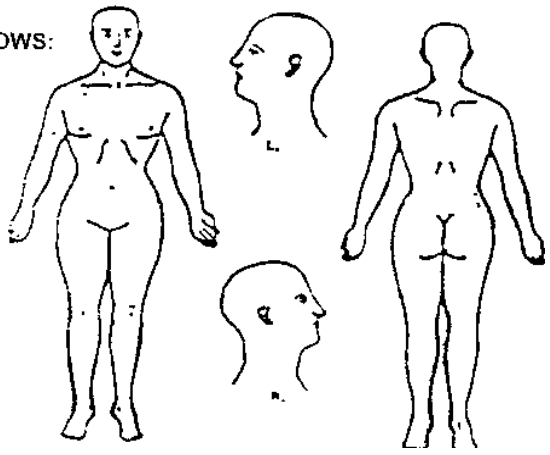
| *Your current complaints:* | *Started:* | *What makes it worse:* | *What makes it better:* |
|---|---|---|---|
| A. _____ | _____ | _____ | _____ |
| B. _____ | _____ | _____ | _____ |
| C. _____ | _____ | _____ | _____ |

PLEASE MARK THE DIAGRAM AS FOLLOWS:

P=PAIN
N=NUMB
R=RADIATING
B=BURNING
T=TINGLE



◘ Are your current complaints due to an accident or injury? Y / N

If yes, what was the date of injury: _____/_____/_____

Please <u>circle</u> the cause of injury:

WORK AUTO ACCIDENT OTHER

If OTHER, please explain: _____

_____

◘ Lost days from work? Y / N How Many? _____

*I certify this information is accurate and truthful.*

_____ _____/____/_____

*Signature (Parent, if minor)* *Date* MM / DD / YYYY

***NOTE: If this account is turned over to a collection agency, a maximum collection fee of 50% of the outstanding balance will be added to the account balance" (_____ ) Patient Initials***

# 21st Century Chiropractic
# Office, Financial, Privacy and Consent to Treat Policies

It is our intent and goal to conduct our financial and office policies in a manner that will provide you with the best possible care, at an affordable price. If you have any questions for office staff or need to speak with the doctor, we will do our best to accommodate you. As a part of our service and communication commitment to you, we ask that you review the following office policies:

1. Payment is expected at the time of each visit: If full payment cannot be made, specific arrangements for payment must be made. You may pay for your services at this office in full by: cash, check, Visa or MasterCard. If you elect to use a health insurance policy, liable insurance company policy, or workers compensation insurance to pay for your care:

- We will submit your primary insurance claims in an efficient and timely manner.
- **Secondary or supplemental insurance** claim filings are your responsibility. We will do our best to answer your questions, provide advice or print another bill statement for your submission.
- We will properly collect your co-pay and/or deductible payments at the time of service or provide you with the opportunity of making fair and reasonable financial arrangements that will enable you to receive the care you need. Any account balance older than 60 days will be subject to an **interest charge** of 1.5% per month (18% per annum).
- If we are billing your private health insurance, or your company's workers compensation insurance, we will pursue your insurance claim for **60 days**, after which time we will expect you to take care of payment. It will be your responsibility to follow up with your insurance company if they have not paid within this time frame.
- **Due to postage/office expenses, it is our policy to "zero out" your account if you owe us less than $1.00 or we owe you less than $1.00.**
- We will provide you with a **monthly statement of charges** of any outstanding balance that may be present. Please review this and promptly inform us if you have any questions or are not in agreement. We will assume these account records to be accurate and mutually agreeable if no questions or concerns are brought to our attention by the next statement date. If you do not receive a billing statement, please notify us promptly as billing statements are sent as a service to you enabling you to be current on your account. **Failure to receive a billing statement** in no way nullifies any account balance, or financial responsibility you may have at this office.

2. We will do our best to schedule your appointments at a convenient time. 24-hour notice is requested if you are unable to keep your scheduled appointment. A **$15.00 fee** may be charged to you for missed or rescheduled appointments, when 24-hour notice is not provided.

3. **X-rays** are a legal record that becomes the responsibility of this office. They are maintained for at least 10 years as a permanent part of your private medical record. We want to support any need that you might have to check the x-rays out for another doctor to review. In order for the x-rays to leave the possession of this office, we require a written request signed by you, (guardian or parent if minor). After the request is received, we require at least one working day to process your request. If you request this office to mail the x-rays, there will be a $5.00 charge for postage. This fee must be prepaid.

4. **Your confidential patient records** are available for your personal review on the office premises, upon your request with one working days notice. You are entitled to amend the records if you desire. We are happy to make a copy of a particular form or letter in your file. However, if a substantial portion of your record or multiple document copies are requested, we must have a signed written request from you, (guardian or parent if minor). A minimum file copy charge of $10 or more will be assessed. This fee will be payable at the time of receipt of the file copies. Your signature on this form gives consent to the use or disclosure to health care providers or sureties listed on your office forms, of your protected health information by 21st Century Chiropractic (here after referred to as 21CC) for the purpose of diagnosing or providing treatment to you, obtaining payment for your health care bills or to conduct health care operations of 21CC.

5. **I have read, understand and agree** to these 21st Century Chiropractic office and financial policies. I recognize and agree that insurance coverage, policies coverage, and related payments are ultimately my personal responsibility; as are the charges incurred in this office and hereby waive the statute of limitations for collections. If my bill becomes delinquent and is sent to a collections company I hereby agree to paying the cost incurred by 21CC for the collection, that will be added to my outstanding balance as an administrative fee, not to exceed 50% of my outstanding balance at the time it is turned over to the collections company. As a courtesy to you, we routinely submit charges to your insurance company for treatment received in our office. Even though we are billing that company, you are still responsible for payment of these charges in the event that the insurance company does not pay. Your insurance company may also deny payment for services which are not part of your insurance coverage, such as massage therapy if your plan does not cover that service. In this case, your insurance company will deny payment, and you will still be liable for the balance owing for the services provided. If your insurance company decides that a treatment is 'investigational' or '"not covered', the balance of the services performed is still your responsibility. By signing this form, you agree to pay 21st Century Chiropractic the outstanding balance for any services that are deemed 'investigational' or 'not covered' by your insurance company.

**By signing this form, I agree to be held responsible for any charges for services or products that I have received that my insurance company does not pay for.**

_____ _____

Signature of Patient or Personal Representative Date mm/dd/yyyy

_____

Printed Name

_____ _____

Witness Name Date

# Informed Consent For Treatment At 21st Century Chiropractic PLLC

(to include Examination, Chiropractic, , Massage and Physiotherapy)

***Please read this consent form, discuss it with your clinician if you would like to, and sign where indicated at the bottom***.

Physicians who use spinal or extremity manual therapy techniques, such as joint adjustment or manipulation or mobilization, acupuncture, or various types of physiotherapy such as electric stimulation, ultrasound, traction, massage, exercise or soft tissue techniques, are required to inform patients that there are or maybe some risks associated with such treatment, in particular:

A) Some patients have experienced muscle and ligament sprains or strains, soreness, or spinal and rib fractures following spinal manual therapy or extremity manual therapy.

B) There have been reported cases of injury to a vertebral artery following neck adjustment, manipulation and/or mobilization. Such vertebral artery injuries may cause stroke, which may result in serious neurological injury and/or physical impairment. This form of complication is a rare event, and a direct cause and relationship to manipulation/mobilization has not been scientifically established.

C) There have been reported cases of disc injuries following spinal manual therapy, although scientific studies do not clearly demonstrate that such injuries are caused, or maybe caused, by adjustment or manipulative techniques and such cases are also rare.

D) Acupuncture complications can include infection, punctured or collapsed lung, bruising or soreness.

E) Physiotherapy or massage complications can include soreness, bruising, allergic skin reactions or burns.

Treatments provided at this clinic, including spinal adjustment, manipulation and/or mobilization, physiotherapy, massage and acupuncture have been the subject of much research conducted over many years and have been demonstrated to be appropriate and effective treatments for many common forms of spinal pain, muscle and joint pain, weakness or numbness in the shoulders/arms/legs, headaches and other similar symptoms. Treatment provided at this clinic may also contribute to your overall well-being, and significantly improve the complaints that brought you to this office. The risk of serious injury or serious complication from manual treatment is substantially lower than the risk associated with many medications, and other treatments and procedures frequently given as alternative treatments for the same forms of musculoskeletal pain and other associated syndromes.

I understand that chiropractic treatment (spinal adjustments, mobilization) will be performed by a licensed Chiropractic Physician and Acupuncture will be performed by a Chiropractic Physician who is a Board Certified Acupuncturist. The massage will be performed by a graduate of a massage therapy school. Physiotherapy will be performed by a Chiropractic Physician, or an employee trained in our office as a Chiropractic assistant. In all cases your treatment in this office will be directed and prescribed by a Chiropractic Physician, who will evaluate your individual case, provide an explanation of care and a suggested treatment plan, or alternatively a referral for consultation and/or further evaluation if deemed necessary, and the Physician will answer your questions about other alternatives available to you for treatment outside of this office.

**Acknowledgment**: I acknowledge I have discussed, or have been given the opportunity to discuss with the Physician the nature of treatment available to me in this office in general, and my plan of treatment in particular as well as the contents of this consent form. I also clearly understand that I have the right to refuse treatment in this office if I am not comfortable with the risks associated.

**Agreement**: I agree that any dispute or allegation of malpractice, or any loss or injury that is related to examination or treatment at 21st Century Chiropractic PLLC (referred to as 21CC) and including allegations of improper, negligent or incompetent evaluation or treatment will be resolved by **submission to binding arbitration _____(Initials)** as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are waiving their right to have any such dispute decided in a Court of Law before a jury, and instead are accepting the process and determination of binding arbitration. I agree that it is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the healthcare provider or employees, associates or contractors thereof, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn, or parents, relatives or interested parties at the time of the occurrence regarding your treatment by 21CC giving rise to any claim or from pursuing legal remedy outside of this agreement.

**Consent:** I consent to the treatment(s) offered or recommended to be performed at 21st Century Chiropractic PLLC by the Chiropractic Physicians, Associates, massage therapist and or staff, including joint adjustment or manipulation or mobilization to the joints of my spine (neck and back), pelvis and extremities (shoulder, upper limbs and lower limbs), massage therapy or physiotherapy as determined by the recommendations of the Physician(s) at 21CC. I intend this consent to apply to all my present and future treatments at this clinic, unless rescinded by me in writing, and it is given with understanding and without duress or pressure.

| | | |
|---|---|---|
| _____ | _____ | _____ |
| Patient Signature (Or Legal Guardian) | Signature of Guardian (when applicable) | Date |
| Name:_____ | Name: _____ | _____ |
| (Please print name of patient) | (Please print name of Gaurdian) | Date |
| Name:_____ | Name: _____ | _____ |
| (Please print name of Witness/Translator) | (Signature of Witness/Translator) | Date |

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Dr. Alan R. Barnes D.C.

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# Notice of Privacy Practices

I acknowledge that I was provided with a copy, or was given the chance to review/receive and declined a copy, of the 21st Century Chiropractic PLLC Notice of Privacy Practices.

| _____ | _____ | _____ |
|---|---|---|
| Patient Name (Print) | Signature of Patient (parent/guardian if minor) | Date |

If completed by a patient's personal representative please complete the following:

| _____ | _____ | _____ |
|---|---|---|
| Representative Name (Print) | Signature of Representative | Relationship to patient |

For 21CC Use only:

I have made a good faith effort to obtain written acknowledgement of review/receipt of 21st Century Chiropractic Notice of Privacy Practices but was unable to for the following reason:

____ Patient refused to sign
____ Representative refused to sign
____ Other _____

| _____ | _____ |
|---|---|
| Staff Name | Date |