Rozell Chiropractic

OFFICE POLICIES AND INFORMATION

- We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. If you find that you do need to cancel or reschedule your appointment please call the office as soon as possible, if we are unable to answer your call please leave a message. We understand that some cancellations may be very last minute, but a last-minute call is preferable to no call at all.
- **FAILURE TO CALL WILL RESULT IN A $20.00 NO SHOW FEE. THIS IS NOT COVERED BY YOUR INSURANCE.**
- If you are going to be more than 5 minutes late for your appointment, please call the office and let us know. If we are unable to answer your call, please leave a message.
- If you have insurance, we will check your chiropractic benefits at your first visit. You will be responsible for all deductibles (if applicable), co-insurance and co pays that your plan dictates. **Please remember it is your responsibility to know your insurance benefits, to find out your insurance benefits you can call the Member Services number that is located on the back of your card.**
- Statements will be sent out for any balances owed. If after 3 statements have been sent and no payment has been made the balance will be turned over to collections. **You will be responsible for all collection and/or attorney fees incurred.**

I have read and understand the above:

_____ _____ _____

Print Name Signature Date

Rozell Chiropractic

Patient Intake Form

MM DD YYYY

First Name:	Last Name:	Date Of Birth:

Home Phone:	Mobile Phone:	Work Phone:

@E-Mail:	Preferred Communication: (Circle) H M W E@

Street Address:	Apt/Suite #:

City:	ZipCode:	State:

SSN:	Gender: ♀ Female ♂ Male	Preferred Language: ❑ English ❑ Other _____

Race & Ethnicity:

❑ American Indian or Alaska Native ❑ Hispanic or Latino
❑ Asian ❑ Native Hawaiian or Other Pacific Islander
❑ Black or African American ❑ White ❑ Other

Marital Status:

❑ Single ❑ Married ❑ Other
❑ Divorced ❑ Widowed ❑ Separated

Emergency Contact Name:	Phone:	Relationship:

Primary Care Provider Name:	▫Phone:

Street Address:	Apt/Suite #:

City:	ZipCode:	State:

Employer/Company Name:	Phone:

Street Address:	Apt/Suite #:

City:	ZipCode:	State:

Job Title/Position:	Currently Working: ❑ Yes ❑ No ➪ Date Stopped Working:

Insurance Detail

Primary Insurance Coverage

Insurance Company Name:		Policyholder Name:
Insurance ID #:		Group Number:
Plan Name:	Phone Number:	
Street Address:	Suite/Unit #:	
City:	ZipCode:	State:
(Office Use) Policy Effective Date(s):		Payer ID:
Co-Pay $:	Co-Insurance %:	Deductible:

Secondary Insurance Coverage

Insurance Company Name:		Policyholder Name:
Insurance ID #:		Group Number:
Plan Name:	Phone Number:	
Street Address:	Suite/Unit #:	
City:	ZipCode:	State:
(Office Use) Policy Effective Date(s):		Payer ID:
Co-Pay $:	Co-Insurance %:	Deductible:

Financially Responsible Party

❑ Self ❑ Other (If Other Please Complete Section Below)

First Name:	Last Name:	Date Of Birth:
Home Phone:	Mobile Phone:	Work Phone:
@ E-Mail:	Relationship With Patient:	
Street Address:	Apt/Suite #:	
City:	ZipCode:	State:

Medical Detail

Reason For Your Visit

MM DD YYYY

☐ Wellness & Health Maintenance		
☐ Injury, Pain Complaint, or Ailment	Date Of Injury (When Did Your Pain Start?)	
☐ Accident ☐ Automobile Related Accident ☐ Other Type Of Accident	Date Of Accident: MM/DD/YYYY	State: Where Accident Occurred MM/DD/YYYY
Please Provide Brief Details Of Your Injuries & Pain:		

Referring Provider

☐ I Was Referred By My Primary Care Physician (Same Doctor Listed On First Page)

☐ I Was Referred By Another Doctor (Please Fill Out Doctor Info Below)

Referring Provider Name:		Phone:
Street Address:	Apt/Suite #:	@ E-Mail:
City:	ZipCode:	State:

Representative Details (If You Are Being Represented By An Attorney For An Accident Please Provide Info)

Referring Provider Name:		Phone:
Street Address:	Apt/Suite #:	@ E-Mail:
City:	ZipCode:	State:

Medical History

Lifestyle

MM DD YYYY

Are You A Smoker? ❑ Yes ❑ No	If Yes ➪ How Often? _____ /Day /Week
Do You Drink Alcohol? ❑ Yes ❑ No	If Yes ➪ How Often? _____ /Day /Week
Do You Exercise? ❑ Yes ❑ No	If Yes ➪ How Often? _____ /Day /Week

Have You Ever Been Hospitalized? ❑ Yes ❑ No	Have You Had Any Surgeries? ❑ Yes ❑ No
If Yes, Please List Dates/Details:	

Do You Have Any Allergies? ❑ Yes ❑ No ➪ Do You Require Medical Treatment For Your Allergies? ❑ Yes ❑ No

If Yes, Please Provide Details:

Do You Take Any Medications? ❑ Yes ❑ No

Please List All Medications & Dosage (How Much & How Often?)

Please Provide Any Other Medical Information You Feel The Doctor Needs To Know About

_____ Patient Signature

_____ Date

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Informed Consent for Treatment

Patient Name:

Physicians and other health care providers are required to obtain your informed consent before starting treatment.

I, _____, do hereby give my consent to the performance of chiropractic treatment that may consist of manipulations/adjustments, physical medicine and exercises. I understand that the manipulations/adjustments will involve movement of the joints and soft tissues that is considered to be one of the safest and most effective forms of therapy for musculoskeletal problems.

I am aware that there are possible risks/complications associated with my treatment. Tests have been performed to minimize these risks. I freely assume the risks of treatment after having been informed of the possible risks/complications associated with my treatment as follows:

Soreness: It is common to experience muscle soreness during treatment.
Uncomfortableness: Temporary symptoms (dizziness, nausea) can occur, but are rare.
Fractures/Joint Injury: Underlying physical defects, deformities or pathologies (osteoporosis) may cause susceptibility to injury.
Stroke: The evidence to date is insufficient to establish a causal relationship between chiropractic and stroke

Treatment Results:
I understand there are benefits associated with treatment including decreased pain, improved mobility and function, and reduced muscle spasms. However, I also understand there is no guarantee that I will achieve these benefits during my care, as the practice of medicine, including chiropractic, is not an exact science.

Alternative Treatments Available:
Reasonable alternatives to treatment have been explained to me including rest, home therapy, exercises, medication and possible surgery.

I agree to treatment by my doctor and such persons of the doctor's choosing and provide my informed consent for treatment.

I HAVE READ OR HAVE HAD READ TO ME THE ABOVE EXPLANATION OF CHIROPRACTIC TREATMENT. ANY QUESTIONS REGARDING TREATMENT HAVE BEEN ANSWERED TO MY SATISFACTION.

_____ _____/_____/_____

Patient Signature

Rozell Chiropractic

HIPAA Notice of Privacy Practices

1254 University Dr. Suite 120
Edwardsville, IL 62025
618-307-9383

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.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physicians practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical student, licensing, and conducting or arranging for other business activities. For example we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose our protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity and National Security: Worker's Compensation: ;Inmates: Required Uses and Disclosures: to investigate or determining our compliance with the requirements of Section 164.500.
Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of you protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operation. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclose your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying your physician or the office manager. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Office Phone Number.

Signature below is acknowledgement that you have received this Notice of our Privacy Practices:

Print Name_____Signature_____Date_____