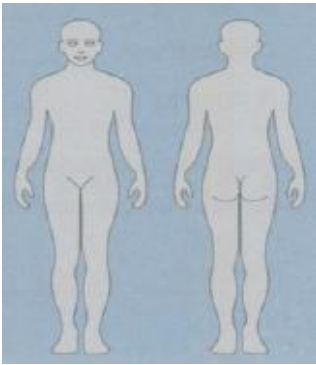


INFORMATION/APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete ALL questions. If you need help please ask the receptionist. PLEASE PRINT.

Today's Date _____
Name _____ Home Phone _____ Work Phone _____
Address _____ City _____ State _____ Zip _____
Age _____ Birth date _____ Marital Status: S M W D Social Security # _____
Number of Children _____ How did you hear about our office? _____

Please circle one payment type: Cash Check Master Card/Visa
Your Employer _____ Occupation _____ Years On Job _____
Do you have Medicare? Yes _____ No _____ Do you have Medicaid? Yes _____ No _____
Name of Spouse or Parent _____ Their Birth date _____
Spouse Employed By _____ Occupation _____ Years On Job _____
Does your spouse have health insurance at work? Yes _____ No _____



COMPLETE THESE DIAGRAMS

If you are in pain, please mark the exact location of your pain on the diagram.

What is your main complaint? _____

What event, if known, brought about this problem? _____

How long have you suffered with this problem? _____

Is the pain: Sharp? _____ Dull? _____ Throbbing? _____ Constant? _____ Intermittent? _____

What activities make your condition/pain worse? _____

What activities give you some temporary relief? _____

What have you tried that DID NOT work? _____

Is your condition interfering with work? _____ Sleep? _____ Family? _____ Routine? _____ Other? _____

Please explain: _____

On a scale of 1-10 (1=minor, 10=worst possible), please rate:

The severity of your symptoms: 1 2 3 4 5 6 7 8 9 10

Any other complaints? _____

Please list any drugs or medications you are currently taking: _____

Do you have a family history of Heart Disease? _____ Cancer? _____ Diabetes? _____ Other? _____

Have you had or do you currently suffer from any of the following:

- | | | | |
|--|--|---|--------------------------------------|
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Depression | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Frequent Colds/Infections | <input type="checkbox"/> Ears Ringing | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Digestive Difficulties | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Menstrual Problems/Pain | <input type="checkbox"/> Breathing Difficulties | <input type="checkbox"/> Stiff Neck |

Type of Insurance: ___ Worker's Comp. ___ Health Insurance ___ Automobile Insurance ___ None

Is your condition due to an accident? Yes ___ No ___ Date of accident? _____

Type of accident? Auto ___ Work/On Job ___ At Home ___ Other _____

Have you been in an auto accident? Past Year ___ Past 5 Years ___ Over 5 Years ___ Never ___

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered will be immediately due and payable.

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.

Insurance cases: On all insurance assignments, the deductible should be met in the beginning unless prior arrangements are made.

In the event that my account becomes 60 days past due and I have not responded to monthly statements, I understand that my account will be turned over to an attorney for collections. I agree to pay any and all fees charged by the attorney for the collection process.

I (we) authorize Dr. Montgomery to perform diagnostic x-rays if needed in this case so that a complete analysis can be made of the present musculoskeletal problem (or illness) and to diagnose or administer whatever treatment is deemed necessary.

Patient's Signature _____ Date _____

Or Guardian Signature _____ Date _____

FOR LADIES

To the best of my knowledge, I am NOT pregnant and the above named Doctor has my permission to perform x-rays if needed for diagnostic interpretation.

Patient's Signature _____ Date _____

Terms of Acceptance

When a person seeks Chiropractic care and we accept a person for such care it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent confusion.

Adjustment: A specific application of forces to facilitate the body's correction of the vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spine resulting in nerve dysfunction, resulting in the lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. Our focus in this office is the vertebral subluxation. However, if we encounter non-chiropractic or unusual findings we will advise you. If you desire advice, diagnoses or treatment for those findings we recommend that you seek another healthcare provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to locate, analyze and correct vertebral subluxation by specific adjustments.

I, _____ have read and fully understand the above statements.
(Print name)

All questions regarding the chiropractor's objective to my care in his office have been answered to my complete satisfaction. I therefore accept care on this basis.

Signature: _____ **Date:** _____

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____
Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive Chiropractic care. If you agree sign below.

Signature: _____ **Date:** _____



OFFICE FINANCIAL POLICY

CASH

1. All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff.
2. This office may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings.
3. Any payments made with a check that are returned for insufficient funds will incur a \$25 processing fee.

INSURANCE

1. If you have insurance, we will gladly accept assignment with the following exceptions and regulations, provided we have prior certification from your insurance company.
2. We accept assignment for the initial treatment plan only. Any follow-up visits will be payable when services are rendered. Once you have been discharged from active care and placed on maintenance care, we will continue to file your insurance but require full payment per visit.
3. We accept assignment as a courtesy to you; you are responsible for your entire bill should your insurance company not pay any of the anticipated charges for any reason. We are not a mediator between you and your insurance company and will not enter into any dispute with the same, as your contract is between you and your insurance company.
4. Whenever you receive any worksheets from your insurance company or explanation of benefits, please bring this information into this office as soon as possible. We must have a copy of this to determine whether proper payment has been made. If you should receive a check from your insurance company during our billing, you must bring it into the office upon receipt. If any over-payment exists after all insurance billing has been done, we will issue you an overpayment check - it will not come from your insurance company. All insurance payments, regardless of which company issues a check, first, are applied to your account as long as any balance is due.

5. Any services not covered or coverage reductions by your insurance will be the patient's responsibility.
6. This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster, or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.
7. If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, the bill is due and payment in full immediately; regardless of any claims submitted. If patient has a credit on his or her account, refunds are processed at the beginning of the next month and are dependant on insurance reimbursement if applicable. Any refund given from a credit card payment will be charged a 3% processing fee.
8. If you have questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the Doctor.
9. I, the undersigned, hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Further I authorize assignment of my insurance rights and benefits directly to this provider and also authorize the release of such information as is needed to process Insurance claims by provider or agent. I designate this provider, practice and Agent as Authorized Representative with Durable Power of Attorney in insurance related matters. I understand that I am responsible for all charges which may include legal fee, collection fees or other expenses incurred by the provider in collecting my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.
10. I hereby authorize and direct my insurer to issue payment for services rendered by Montgomery Chiropractic Wellness Center, LLC. Regardless of my benefit, I understand that I am financially responsible for the fees for services rendered, that finance charges may accrue on past due balances, and that failure to pay will result in the account being turned over to an attorney for collection. I agree to pay all attorney fees and court costs incurred in collecting any unpaid balances for services rendered.

Thank you.

I have read and understand the Financial Office Policy and agree to abide by these terms.

Patient's Signature

Date



MONTGOMERY
CHIROPRACTIC WELLNESS CENTER

Your Informed Consent

Although Chiropractic is reported to be the safest health care system in the world, some say there are very slight risks associated with it. We feel that it is our responsibility to let you know:

- a. Risk of stroke is reported to be 1 in 5-8 million¹⁻³ and the cause has yet to be determined.
- b. While extremely rare, there have been reports of ligament sprains, and even rib fractures reported.
- c. There have been rare reports of disc injuries although no clinical scientific study has ever demonstrated chiropractic care to be the cause.

Chiropractic care has been proven to be both, clinically and very cost effective. The risk of injuries and complications is so small that chiropractors carry the lowest malpractice insurance premiums of all the health care professions in the world.

Compared to traditional medical/drug/surgical care, which has a yearly death rate of approximately 560,000 people in North America⁴⁻¹², Chiropractic is your safest health care system.

I have read and understand the above consent, and have had the opportunity to discuss it with my chiropractor.

I consent to care by Dr. Montgomery and extend this consent to include all doctors of this Chiropractic Wellness Center. This consent applies to all present and future care for me and my family.

Your Name: _____ Date: _____

Your Signature: _____

References

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- 2) Rothwell DM, Bondy SJ, Williams JI. Chiropractic manipulation and stroke: a population-based case-control study. *Stroke* 2001;32:1054-60.
- 3) Haldeman S, Kohlbeck FJ, McGregor M. Risk factors and precipitating neck movements causing vertebral artery dissection after cervical manipulation. *Spine* 1999; 24(8):785-94.
- 4) Lazarou J, Pomeranz BH, Corey PN. Incidence of adverse drug reactions in hospitalized patients: a meta-analysis of prospective studies. *JAMA* 1998 Apr 15;279(15):1200-5.
- 5) Suh DC, Woodall BS, Shin SK, Hermes-De Santis ER. Clinical and economic impact of adverse drug reactions in hospitalized patients. *Ann Pharmacother* 2000 Dec; 34(12):1373-9.
- 6) Thomas EJ, Studdert DM, Burstin HR, et al. Incidence and types of adverse events and negligent care in Utah and Colorado. *Med Care* 2000 Mar; 38(3):261-71. Thomas EJ, Studdert DM, Newhouse JP, et al. Costs of medical injuries in Utah and Colorado. *Inquiry* 1999 Fall; 36(3):255-64. [Two references]
- 7) Weinstein RA. Nosocomial Infection Update. *Emerg Infect Dis.* 1998 Jul-Sep; 4(3):416-20.
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- 9) For calculations detail, see "unnecessary Surgery." Sources: HCUPnet, Healthcare Cost and Utilization Project. Agency for Healthcare Research and Quality, Rockville, MD. Available at: <http://www.ahrq.gov/data/hcup/hcupnet.htm>. Accessed December 18, 2003. US Congressional House Subcommittee Oversight investigation. *Cost and Quality of Health Care: Unnecessary Surgery*. Washington, DC: Government Printing Office; 1976. Cited in: McClelland GB, Foundation for Chiropractic Education and Research. Testimony to the Dept. of Veterans Affairs' Chiropractic Advisory Committee. March 25, 2003.
- 10) Starfield B. Is US health really the best in the world? *JAMA* 2000 Jul 26; 284(4):483-5. Starfield B. Deficiencies in US medical care. *JAMA* 2000 Nov 1; 284(17):2184-5.
- 11) HCUPnet, Healthcare Cost and Utilization Project. Agency for Healthcare Research and Quality, Rockville, MD. Available at: <http://www.ahrq.gov/data/hcup/hcupnet.htm>.
- 12) Injuries in hospitals pose a significant threat to patients and a substantial increase in health care charges [press release]. Rockville, MD: Agency for Healthcare Research and Quality. October 7, 2003. <http://www.ahrq.gov/news/ress/pr2003/injurypr.htm>.

NOTICE OF PRIVACY PRACTICES

This notice describes how health 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 health information is important to us.

Policy Statement

This practice is committed to maintaining the privacy of your protected health information (“PHI”), which includes information about your medical condition and the care and treatment you receive from the Practice and other health care providers. This Notice acknowledges how your PHI may be used and disclosed to third parties for the purposes of your care, payment for your care, health care operations of the Practice, and for other purposes permitted or required by law. This notice also details your rights regarding your PHI.

The Practice:

- (a) Is required by federal law to maintain the privacy of your PHI and to provide you with is Privacy Notice detailing the Practice’s legal duties and privacy practices with respect to your PHI.
- (b) Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI that which is provided for under federal law.
- (c) Is required to abide by the terms of this Privacy Notice.
- (d) Reserves the right to change the terms of this privacy Notice and to make the new Privacy Notice provisions effective for all your PHI that it maintains.
- (e) Will distribute any revised Privacy Notice to you prior to implementation.
- (f) I have received a Notice of Privacy Practices from Montgomery Chiropractic Wellness Center, LLC.
- (g) Will not retaliate against you for filing a complaint.

EFFECTIVE DATE

This Notice is in effect as of 04/15/03.

STATE LAW

A copy of the State HIPPA laws will be available to me at any time for my review, and a copy will be given to me upon my request.

PATIENT ACKNOWLEDGMENT

By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Patient _____

Date _____

Office UseF/C : INS MC MD IO WC AA PI SP MC # _____Included : Insurance Card Copy Employer Claim Form Referral / Script**PATIENT INFORMATION**

Thank you for choosing Montgomery Chiropractic. In order to help us complete records and submit accurate bills to your insurance company, please assist us by providing the following information :

Today's Date : _____ Patient's Soc. Sec. # : _____

First Name : _____ M.I. : _____ Last Name : _____

Mailing Address : _____

Zip Code : _____ City : _____ State : _____

Home # : (_____) _____ Work : (_____) _____ Cell : (_____) _____

Date of Birth : _____ Male Female

Employer : _____ Occupation : _____

Referred By : Self Friend Insurance Carrier Primary Physician Other _____**INSURANCE PATIENTS***Please complete the following section and present your Insurance Cards.*

PRIMARY INSURANCE		SECONDARY INSURANCE	
Relation to Insured:	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
Complete the following Insured information if RELATION is other than SELF.			
Insured's Name:			
Insured's Birthdate:			
Insured's Insurance ID:			
Male or Female:			
Employer:			
Complete the following Insured information if it differs from the Patient's.			
Insured's Address:			
City, State, Zip:			
Phone Number:	(_____) _____	(_____) _____	

ACCIDENT PATIENTS

CLAIM FILING INFORMATION	
WORK COMP OR MEDPAY INFORMATION	ATTORNEY INFORMATION
Date of Injury:	<input type="checkbox"/> Attorney Only - <u>no</u> WC or Medpay Info
Insurance Carrier Name:	Name :
Carrier Address:	Address :
City, State, Zip:	City, State, Zip :
Adjuster's Name:	Contact :
Adjuster's Phone : (_____) _____	Phone : (_____) _____
Claim Number:	File No. :

I, the undersigned, hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Further I authorize assignment of my Insurance rights and benefits directly to this provider and also authorize the release of such information as is needed to process Insurance claims by provider or agent. I designate this provider, practice, and agent as Authorized Representative with Durable Power of Attorney in insurance related matters. I understand that I am responsible for all charges which may include legal fee, collection fees or other expenses incurred by the provider in collecting my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.

Patient Signature : _____ Date : _____