BACK TO HEALTH CHIROPRACTIC WELLNESS CENTER, P.C.
10990 Chicago Drive ▪ Zeeland, MI 49464
(616) 546-3500

FINANCIAL POLICY & AGREEMENT

SOURCE OF PAYMENT
The Financial Policy of Back to Health Chiropractic Wellness Center, P.C. (the "Company") requires payment in full for all services rendered at the time of your visit, unless other arrangements have been made. The Company generally accepts payment from the sources identified below. If you have any questions related to your available sources of payment, please ask any staff member of the Company.

PRIVATE PAY (NO INSURANCE) – If you do not have insurance or another party who may be responsible for paying for your health expenses, you are responsible for payment and must bring your account current at each visit. As a service to you, the Company offers no-interest and low-interest financing through CareCredit Patient Payment Plans. Please ask a staff member of the Company for more information related to payment plans, if you are interested.

PERSONAL INJURY or AUTOMOBILE ACCIDENTS – Injuries sustained as a result of an auto- related incident will be submitted under a personal injury claim. Please provide your automobile insurance information, claim number, insurance adjuster's contact information and health insurance information so that the Company can promptly process your claims. If an attorney is handling your case, please notify the Company as soon as possible. Although you are ultimately responsible for payment, the Company will wait for payment until your claim is settled, so long as you are an active patient. If you suspend or terminate care, any fees for services are due immediately.

"ON THE JOB" INJURY (Workers' Compensation) – If you are injured on the job, your care may be paid for under your employer's Workers' Compensation insurance policy. You will need to inform your employer of the accident. Please provide the contact information for your employer's Workers' Compensation insurance carrier, your claim number, and your health insurance information so that the Company can promptly process your claims. If an attorney is handling your case, please notify the Company as soon as possible. Although you are ultimately responsible for payment, the Company will wait for payment until your claim is settled, so long as you are an active patient. If you suspend or terminate care, any fees for services are due immediately.

MANAGED CARE PLANS – The Company are preferred providers for the following HMO's and PPO's: Aetna, ASR Health (Physician's Care), Assurant Health, Blue Care Network, Blue Cross Blue Shield, Cigna, Cofinity, Humana, Medicare, Meridian, Meritain, Priority Health, United Health Care. Please note your insurance may be a subsidiary of the previously listed insurance companies.

Please contact your HMO or PPO directly to discuss the benefits available to you, your responsibility for paying cost-sharing amounts, and any referral requirements.

FLEX PLANS/MEDICAL SAVINGS ACCOUNT PLANS – Upon request, the Company will provide you with a statement of your charges for your use in seeking reimbursement under a Flex Plan or Medical Savings Account Plan.

MEDICARE – The Company accepts Medicare reimbursement for services rendered to you. However, Medicare covers only medically necessary manipulation of the spine and will only pay for 80% of the allowable fee once the deductible has been met. You will remain responsible for the remaining portion of the allowable fee, any deductible, and all other services or tests (including X-rays and examinations). The Company will make every reasonable attempt to secure payment for your services from Medicare.

INSURANCE – The Company accepts assignment of insurance benefits in lieu of cash payments for certain services rendered to you. The Company is willing to investigate the availability of insurance benefits, upon request. If so requested, you must provide accurate and up-to-date insurance information. Please be prepared to present your insurance identification card at each visit. The Company's communication with your insurance company is not a guarantee of payment. The Company encourages you to contact your insurance company directly for detailed coverage information. The Company will also assist you if you need help in filing claims with secondary insurance providers.

The Company attempts to keep track of individual insurance plans and the amounts that they typically pay for procedures. However, plans routinely change, thus the estimated insurance payment may vary from your insurance company's actual payment. When your insurance payment is received, any necessary adjustments (credits or debits) will be made to your account.

It is important to remember that your insurance coverage is a contract between you, your employer (if applicable), and your insurance company. While the Company will seek payment from your insurance provider before looking to you for payment, you are responsible for certain upfront fees. These may include, among other fees, co-payments, deductibles and co-insurance amounts, as applicable. You will also be responsible for any amount that is not covered by insurance.

PAYMENT POLICY

1. Payment is due at the time of service, unless other arrangements have been made.
2. For your convenience, the Company accepts cash, checks, CareCredit (payment plan), Visa, MasterCard and Discover.
3. An insurance contract is between you, your employer, and your insurance company; therefore, it is your responsibility to keep the account current.
4. You will be notified when your insurance reimbursement goes beyond 45 days without payment. At that time, you should contact your insurance company to request payment. After 90 days, you will be billed and expected to make payment in full.
5. Patients involved in litigation (law suits) are responsible for payment of their services, as outlined above. In its discretion, the Company may agree to wait for payment until the final disposition of your claims is reached, so long as you are an active patient.
6. Any fees for services rendered will be immediately due and payable if you suspend or terminate care.
7. Any amount paid to the Company relates to services only; x-rays, medical records, and other physical property will remain the permanent property of the Company.
8. 24-hours' notice is required when cancelling or rescheduling appointments. The Company reserves the right to charge up to the full amount owed for scheduled services in the event you do not cancel with a 24-hours' notice (including no-show appointments). Cancellation fees are your responsibility, will not be charged or submitted to insurance, and must be paid in full before your next visit.
9. In the event that your check is returned due to insufficient funds, you will be assessed a $25 fee.

ASSIGNMENT AND AUTHORIZATION

I hereby assign to the Company all medical and other benefits, including major medical benefits, related to the services provided to me by the Company. I further authorize and direct my insurance carriers (including Medicare, private insurance and any other health or medical plan) to issue payment directly to the Company for services rendered to me and/or my dependents. I understand that I am responsible for any amount not covered by insurance. I also agree to pay the Company any money that I receive from my insurance carrier for services provided to me for which I have not paid the Company.

I hereby authorize the Company to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all my insurance submissions whether manual or electronic. Furthermore, I authorize the release of my medical records, including protected health information, to secure payment and/or to receive medical information pertaining to my case in the Company's clinic.

If my account is delinquent, I agree to pay all expenses incurred by this office to collect the account. This includes, but is not limited to, items such as collection agency fees, court costs, and attorney fees.

My signature indicates my understanding and agreement to the policies stated above.

x_____ _____

Signature of Patient or Parent/Guardian *Date*

_____ _____

Printed Name of Patient *Parent or Guardian Name (if minor patient)*

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20___

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)

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COMMUNICATION STATEMENT

As a convenience to our patients, Back To Health offers three options for appointment reminders. Please choose one option. (All options are a 24 hour notice unless you request otherwise).

Email:
E-mail _____

OR

Phone Call:
Please leave a phone message at _____

OR

Text Message:
A text message at _____

Circle your phone provider:
(Notice – your phone company may charge you extra if you do not have a texting plan)

AT&T/Cingular Verizon Sprint Metro PCS Nextel T Mobile
Cricket Virgin Mobile Other:_____

In addition, we will mail our written communications to the address you specified on your patient intake form unless you request otherwise. This includes email communications with a birthday gift for active patients, occasional news, specials and events. (HIPPA laws do not allow us to give your email or address to third parties). If you wish not to receive our emails, there will be a removal button at the bottom of every email, which will immediately remove you from future mailings. (Sorry, our birthday gift is only available to those patients that are on our email list).

_____

Patient/ Representative Signature Date

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CHIROPRACTIC INFORMED CONSENT

SCOPE OF TREATMENT – Your treatment will primarily involve chiropractic procedures performed by the Doctor of Chiropractic who is named below, or another licensed Doctor or support staff member of Back to Health Chiropractic Wellness Center, P.C. Such chiropractic procedures may involve the manual or mechanical manipulation of your joints and body. The movement may cause an audible "popping" or "clicking" noise, similar to the sound made when you crack your knuckles. As part of your treatment, the Doctor or staff member may also conduct spinal manipulative therapy, adjustments, range of motion testing, muscle strength testing, massage therapy, postural analysis, ultrasounds and x-rays. You must inform the Doctor prior to treatment if you are pregnant, as x-rays may be hazardous to an unborn child.

There are other treatment options available that may be available for your condition that do not involve chiropractic procedures. They include surgery, hospitalization, bracing, physical therapy, steroid injections, prescription drugs, muscle relaxers and over-the-counter painkillers, among others. Please note that these other treatment options also involve their own risks.

RISKS – Chiropractic treatment does not guarantee certain results or promise to cure any ailments. Additionally, as with any health care treatment, chiropractic treatment involves certain complications or risks. These may include, but are not limited to, the following: stiffness or soreness; muscle strain or spasms; aggravation or an increase of symptoms; disc injuries; dislocations; fractures; and stroke. Please also note that remaining untreated may also involve certain risks and may hinder the success of any future treatment.

It is very common for patients to experience slight stiffness after treatment. More serious complications, such as fractures, are rare and generally result from an underlying bone weakness. The incidences of stroke are also exceedingly rare, and have been estimated to occur between one in one million and one in five million cervical adjustments.

Your Doctor will make every reasonable effort to lessen any risks of treatment, but he or she may not be able to anticipate all complications. You are responsible for informing the Doctor if you have a condition or experience any symptoms that may not otherwise come to the Doctor's attention.

CONSENT – I have read, or have had read to me, this Informed Consent. I have discussed it with the Doctor who is named below and have had the opportunity to ask questions about it. By signing below, I acknowledge that I agree to receive treatment, understand the risks involved and consent to that treatment. I intend for this Informed Consent to cover the entire course of my treatment with Back to Health Chiropractic Wellness Center, P.C., including any future conditions for which I may seek treatment. I wish to rely on the Doctor to exercise his or her best judgment during the course of my treatment to accomplish what he or she feels to be in my best interests.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMED CONSENT.

x_____ _____
Signature of Patient or Parent/Guardian *Date*

_____ _____
Printed Name of Patient *Parent or Guardian Name (if minor patient)*

x_____ _____
Signature of Doctor of Chiropractic *Date*

_____
Printed Name of Doctor of Chiropractic

Reaffirmed Consent: _____ _____
Initial *Date*

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name**:_____

Email address: _____

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day / Occasional / Former / Never

Smoking Start Date (Optional): _____

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

Patient Signature: _____ Date: _____
(Parent/ legal guardian signature if patient is under 18 years old)

For office use only

Height: _____ Weight: _____ Blood Pressure:_____ /_____ Pulse: _____