

## Confidential Intake Form

All information you supply is confidential. We comply with all federal privacy standards.

### Reason for visit (mark circle)

- Work Injury -> Date of Injury (DOI): \_\_\_\_\_ Claim #: \_\_\_\_\_
- Auto Injury -> Date of Injury (DOI): \_\_\_\_\_ Claim #: \_\_\_\_\_
- Other (you will describe below)

Today's Date (mm/dd/yyyy)

Who referred you/how did you find out about us?

Previous chiropractic, physical therapy, acupuncture or naturopathic care?  Yes  No

Date of last visit (approx)

Your full name

Preferred Name

Birth date (mm/dd/yyyy)

Age

Gender (for insurance)  Male  Female

Single  Married  Divorced  Widowed  Separated

Gender (if applicable)  M2F  F2M

Marital Status

Spouse's Name

Child's name and age

Child's name and age

Child's name and age

Mailing address

E-mail address

City

State/Province

ZIP/Postal Code

Cell phone

OK to leave Voicemail?

Emergency contact name

Relationship

Telephone

### Employment Details

Your occupation

Your employer

Work Telephone

Work address

City

State/Province

ZIP/Postal Code

Family (PCP) and/or Specialist Doctor (if applicable)

Primary care physician (Family doctor)

Clinic

Telephone

Fax

Specialist

Clinic

Telephone

Fax

\*\*If you would prefer us to NOT communicate with your PCP regarding care, mark "No" and initial:  No Initials: \_\_\_\_\_

Preferred Pharmacy

Pharmacy Telephone

Pharmacy Address

### Insurance Information

Insured's name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Insured's date of birth

Insured's employer

Primary Policy Holder

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Primary's date of birth

Relation to Insured

Insurance company

Member ID # (include alpha prefix)

Group #

Insurance company's address

City

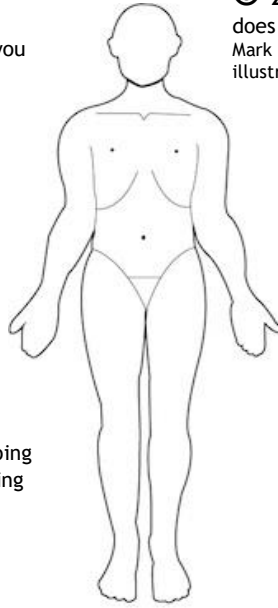
State/Province

ZIP/Postal Code

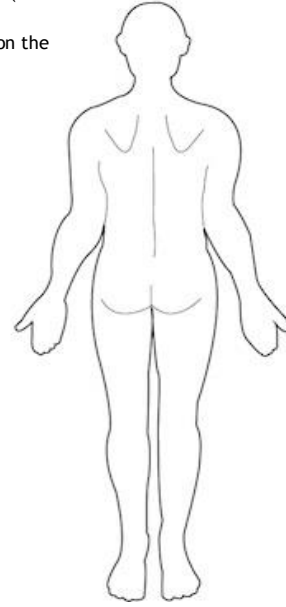
©1. List your current conditions/complaints. Mark the intensity of the symptoms to the right (0-10: 0 being none and 10 the highest conceivable intensity) and its quality (WHAT you feel) below.

	Ave. Pain	Worst Pain
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

- Symptoms:
- |                                |                                |                                 |                                |
|--------------------------------|--------------------------------|---------------------------------|--------------------------------|
| <input type="radio"/> Achiness | <input type="radio"/> Numbness | <input type="radio"/> Tightness | <input type="radio"/> Cramping |
| <input type="radio"/> Nagging  | <input type="radio"/> Tingling | <input type="radio"/> Stiffness | <input type="radio"/> Stabbing |
| <input type="radio"/> Swollen  | <input type="radio"/> Burning  | <input type="radio"/> Soreness  | <input type="radio"/> Sharp    |
|                                | <input type="radio"/> Shooting | <input type="radio"/> Throbbing | <input type="radio"/> Dull     |



© 2. Location (Where does it hurt?) Mark the area(s) on the illustrations.



©3. Have you ever suffered from your current symptoms in the past?

Yes  No If yes, explain:

Year	Cause	Tests done?	Problem resolved completely?	
			<input type="radio"/> No	<input type="radio"/> Yes
			<input type="radio"/> No	<input type="radio"/> Yes
			<input type="radio"/> No	<input type="radio"/> Yes

©4. Have you received any evaluation and/or treatment for your current condition(s)?

Yes  No If yes, explain:

Month/Year	Doctor or therapist	Recommended treatment	Outcome (if applicable)

©5. Please list any other special diagnostic tests that you have had in the past year: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

6. Activities of Daily Living How does this condition currently interfere with your life and ability to function?

	No Affect	Mild Affect	Moderate Affect	Severe Affect		No Affect	Mild Affect	Moderate Affect	Severe Affect
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Grocery shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising out of chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Household chores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Lifting objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Reaching overhead	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Showering or bathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Dressing myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Love life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Getting to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking over shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Gardening/Yard work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Exercising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Work duties	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Athletics/Recreation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Examination Note



**Past personal, family and social history** Please identify your past health history, including accidents, injuries, illnesses and treatments.

<b>7. Have you ever been hospitalized or had surgery?</b>				<input type="radio"/> No <input type="radio"/> Yes If yes, describe:
Year	Reason	Surgery	Outcome	
<b>8. Have you ever had any traumas or accidents? (Falls, car accidents, work injury, sports injury, fractures)</b>				<input type="radio"/> No <input type="radio"/> Yes If yes, describe:
Year	Trauma	Treatment	Outcome	
<b>9. Do you take any medications or supplements (including over the counter eg.Tylenol?)</b>				<input type="radio"/> No <input type="radio"/> Yes If yes, describe:
Name	Reason	x/day	Dose	Since when?
<b>10. Do you have any allergies?</b>				<input type="radio"/> No <input type="radio"/> Yes If yes, list:

**11. Family History**

Some health issues are hereditary. Is there a history of illness (cancer, arthritis, heart disease, depression, diabetes, etc.) in your immediate family?

FAMILY	Relative	Age (if living)	Illnesses	Age at death	Cause of death	
					Natural	Illness
	Mother	_____	_____	_____	<input type="radio"/>	<input type="radio"/>
	Father	_____	_____	_____	<input type="radio"/>	<input type="radio"/>
	Other: _____	_____	_____	_____	<input type="radio"/>	<input type="radio"/>
	Other: _____	_____	_____	_____	<input type="radio"/>	<input type="radio"/>

**12. Social History**

SOCIAL	Sleep (check all that apply):	
	<input type="radio"/> Restful sleep	<input type="radio"/> Snore heavily
	<input type="radio"/> Difficulty Falling asleep	<input type="radio"/> Sleep Face down
	<input type="radio"/> Wake up frequently	<input type="radio"/> Grind teeth at night (bruxism)?
	<input type="radio"/> Sleep < 6h	<input type="radio"/> Sleep 6-8h
	<input type="radio"/> Sleep > 8h	
	How often do you exercise:	<input type="radio"/> Don't <input type="radio"/> About 1x/week <input type="radio"/> 2-3x/week <input type="radio"/> > 3x/week <input type="radio"/> Daily
	Water intake:	<input type="radio"/> <33oz(1L) <input type="radio"/> 33-50oz (1-1.5l) <input type="radio"/> >50oz(1.5L)
	Alcoholic Drinks:	<input type="radio"/> Never <input type="radio"/> <1/day <input type="radio"/> Daily <input type="radio"/> 6-10/week <input type="radio"/> >10/week
	Caffeine use:	<input type="radio"/> Never <input type="radio"/> <1/day <input type="radio"/> Daily <input type="radio"/> 6-10/week <input type="radio"/> >10/week Source of caffeine: _____
	Tobacco use:	<input type="radio"/> No <input type="radio"/> <1x/day <input type="radio"/> <½ pack/day <input type="radio"/> >½ pack/day <input type="radio"/> >1 pack/day Type of tobacco: _____
	Soft drinks:	<input type="radio"/> Never <input type="radio"/> <1/day <input type="radio"/> Daily <input type="radio"/> 6-10/week <input type="radio"/> >10/week
	What vitamins/supplements do you take?	<input type="radio"/> Not taking <input type="radio"/> Glucosamine <input type="radio"/> Chondroitin <input type="radio"/> Calcium <input type="radio"/> Multi-Vitamin <input type="radio"/> Fish Oils <input type="radio"/> Pro-biotics <input type="radio"/> Magnesium <input type="radio"/> Greens <input type="radio"/> B Complex <input type="radio"/> Vitamin C <input type="radio"/> Vitamin D <input type="radio"/> Vitamin E Others: _____
	Describe your eating habits:	<input type="radio"/> Skip breakfast <input type="radio"/> Two meals per day <input type="radio"/> Three meals per day <input type="radio"/> Snacking between meals
	Diet restrictions/intolerances:	_____
	Rate your fatigue level (0-10):	_____ /10
	Rate overall stress level (0-10):	_____ /10
	What are major causes of stress?	<input type="radio"/> Work <input type="radio"/> School <input type="radio"/> Economic <input type="radio"/> Family/Relationships
	Hobbies:	_____



13. Review of systems

Our integrative care focuses on the integrity of all body systems. Please mark the circle beside any condition that you've HAD or currently HAVE:

a. HEENT	b. Integumentary	c. Respiratory	d. Neurological	e. Digestive	f. Endocrine	g. Genitourinary
<input type="radio"/> Blurred Vision	<input type="radio"/> Dry Skin	<input type="radio"/> Asthma	<input type="radio"/> Anxiety	<input type="radio"/> Ulcer	<input type="radio"/> Thyroid Issues	<input type="radio"/> Kidney Stones
<input type="radio"/> Floaters in vision	<input type="radio"/> Psoriasis	<input type="radio"/> Apnea	<input type="radio"/> Depression	<input type="radio"/> Anorexia/Bulimia	<input type="radio"/> Hypoglycemia	<input type="radio"/> Prostate Issues
<input type="radio"/> Hearing Loss	<input type="radio"/> Eczema	<input type="radio"/> Shortness of breath	<input type="radio"/> Pins and needles	<input type="radio"/> Food Sensitivities	<input type="radio"/> Immune Disorders	<input type="radio"/> Erectile Dysfunction
<input type="radio"/> Ringing in ears	<input type="radio"/> Acne	<input type="radio"/> Emphysema	<input type="radio"/> Dizziness	<input type="radio"/> Heartburn	<input type="radio"/> Low Energy	<input type="radio"/> Bedwetting
<input type="radio"/> Loss of taste	<input type="radio"/> Hair Loss	<input type="radio"/> COPD	<input type="radio"/> Headaches	<input type="radio"/> Constipation	<input type="radio"/> Swollen glands	<input type="radio"/> PMS Symptoms
<input type="radio"/> Loss of smell	<input type="radio"/> Rash	<input type="radio"/> Allergies	<input type="radio"/> Numbness	<input type="radio"/> Diarrhea	<input type="radio"/> Frequent Infection	<input type="radio"/> Infertility
<input type="radio"/> Glaucoma	<input type="radio"/> Melanoma	<input type="radio"/> Pneumonia	<input type="radio"/> Multiple Sclerosis	<input type="radio"/> Crohn's Disease	<input type="radio"/> Polycystic Ovarian Syndrome	<input type="radio"/> Urinary Tract infections
<input type="radio"/> Ear infections	<input type="radio"/> None	<input type="radio"/> Tuberculosis	<input type="radio"/> Parkinson's	<input type="radio"/> Irritable Bowel Syndrome	<input type="radio"/> Diabetes	<input type="radio"/> Yeast Infections
<input type="radio"/> Sinusitis		<input type="radio"/> None	<input type="radio"/> Fibromyalgia	<input type="radio"/> Ulcerative Colitis	<input type="radio"/> Hepatitis	<input type="radio"/> Abnormal PAP
<input type="radio"/> Nasal Polyps			<input type="radio"/> Chronic Pain	<input type="radio"/> Celiac	<input type="radio"/> Goiter	<input type="radio"/> STD's
<input type="radio"/> Strep Throat			<input type="radio"/> Mood Disorders	<input type="radio"/> Diverticulitis/osis	<input type="radio"/> None	<input type="radio"/> Decreased Libido
<input type="radio"/> Mononucleosis			<input type="radio"/> None	<input type="radio"/> Gas/Bloating		<input type="radio"/> None
<input type="radio"/> None				<input type="radio"/> Gall Bladder Disease		
				<input type="radio"/> None		

h. Constitutional	i. Cardiovascular	j. General
<input type="radio"/> Fainting	<input type="radio"/> Angina	<input type="radio"/> Cancer
<input type="radio"/> Low Libido	<input type="radio"/> High-cholesterol	<input type="radio"/> Epilepsy
<input type="radio"/> Poor Appetite	<input type="radio"/> High Blood Pressure	<input type="radio"/> AIDS/HIV
<input type="radio"/> Difficulty losing weight	<input type="radio"/> Low Blood Pressure	<input type="radio"/> Alcoholism/Drug dependence
<input type="radio"/> Weakness	<input type="radio"/> Excessive Bruising	<input type="radio"/> Gout
<input type="radio"/> Sudden Weight Change	<input type="radio"/> Poor Circulation	<input type="radio"/> Polio
<input type="radio"/> Fever	<input type="radio"/> Stroke	<input type="radio"/> Rheumatic fever
<input type="radio"/> Chills	<input type="radio"/> Murmurs	<input type="radio"/> Scarlet fever
<input type="radio"/> Night Sweats	<input type="radio"/> A-Fib	<input type="radio"/> Typhoid
<input type="radio"/> None	<input type="radio"/> Heart Disease	<input type="radio"/> Malaria
	<input type="radio"/> None	<input type="radio"/> Post-Nasal Drip

14. What would be the most significant thing that you could do to improve your health? \_\_\_\_\_

15. In addition to the main reason for your visit today, what additional health goals do you have? \_\_\_\_\_

**FOR MEDICARE ONLY**

- At the present, would you describe your health as:  Excellent  Very good  Fair  Poor
- Who do you currently live with? (or intend to live with at the conclusion of this therapy?)  
 Alone  w/Spouse or Partner  w/Children/Relative  w/Personal Care Attendant  Other: \_\_\_\_\_
- Where do you currently live (or intend to live) at the conclusion of this therapy?  
 Private home  Private apartment  Rented room  Group home  Board and care apartment  Assisted living  SNF
- Were you discharged from an inpatient, SNF, or home health treatment within the last 30 days?  Yes  No
- Do you need this plan of care/therapy to return to a previous, or move into a new, living environment?  Yes  No
- What other condition are you currently being treated for? Do you require any durable medical equipment (bath bench, wheelchair, cane, etc.) for these conditions?  
 \_\_\_\_\_  
 \_\_\_\_\_

7. "ADLs" are "activities of daily living" such as eating, bathing, dressing and toileting. What is your current level of independence with these activities?

- |   |  |
|---|--|
| <input type="radio"/> Maximal assistance (you provide 50% of the effort)            | <input type="radio"/> Moderate assistance (you perform 50-75%)           |
| <input type="radio"/> Minimal assistance (require incidental hands-on help)         | <input type="radio"/> Supervision Only (require standby assistance only) |
| <input type="radio"/> Modified Independence (require a device but no physical help) | <input type="radio"/> Complete independence                              |

8. "IADL's" are activities such as cooking, driving, using telephone and shopping. What is your current level of independence with these activities?

- |   |  |
|---|--|
| <input type="radio"/> Maximal assistance (you provide 50% of the effort)            | <input type="radio"/> Moderate assistance (you perform 50-75%)           |
| <input type="radio"/> Minimal assistance (require incidental hands-on help)         | <input type="radio"/> Supervision Only (require standby assistance only) |
| <input type="radio"/> Modified Independence (require a device but no physical help) | <input type="radio"/> Complete independence                              |



## Erisa Agreement

### Assignment of Health Plan Benefits and Rights as well as an appointment and/or designation as my personal representative and an ERISA/PPACA Representative and beneficiary:

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Vida Integrated Health as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that **have been or will be** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy (ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan of this document is to be considered as valid and as enforceable as the original.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name



## Informed Consent

I hereby request and consent to the performance of procedures, which may include, but is not limited to, various modes of physical therapy, massage therapy, acupuncture, trigger point injections, diagnostic x-rays, diagnostic ultrasound, diagnostic lab work including urine, blood, gynecological specimens and body cultures, medical doctor and/or chiropractic manipulations on me (or the patient named below, for whom I am legally responsible) by any licensed clinicians who, now or in the future, treat me while employed by, work or are associated with, or are serving as a replacement or locum, for any Vida Integrated Health clinic, including those working at the center or office listed below or any other office or center.

I have had an opportunity to discuss with the clinicians, and/or with other office or clinic personnel, the nature and purpose of all recommended procedures.

I understand, and am informed that in the practice of medicine, and in the practice of chiropractic, acupuncture, naturopathy and physical therapy, there are some risks to treatments including, but not limited to fractures, disk injuries, strokes, dislocations, sprains and potential exacerbation of symptoms. I do not expect the Vida clinician to be able to anticipate and explain all risks and complications, I wish to rely on the Vida clinician to exercise judgment during the course of the procedures which the Vida clinician deems necessary and, based upon the facts then known, are in my best interest.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below, I agree to evaluation and treatment at Vida. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

\_\_\_\_\_  
Patient Signature

Date \_\_\_\_\_

\_\_\_\_\_  
Patient Name

To be completed by patient's representative if patient is a minor or physically or legally incapacitated

\_\_\_\_\_  
Representative Signature

Date \_\_\_\_\_

\_\_\_\_\_  
Representative Name



## Records Request Authorization

I understand and authorize all Vida Integrated Health clinics to request health information regarding my condition(s) while under treatment at Vida Integrated Health. Vida Integrated Health may request any of the following, as long as it pertains to the treatment and care rendered at Vida Integrated Health, from the entities that I disclose.

- Records of medical history.
- Examinations.
- Consultations.
- X-Ray reports.
- Laboratory studies.
- Operative and pathology reports.
- Physicians' and nurses' notes.
- Hospital records.
- Diagnoses.
- Prescription or treatment information relating to any disease, injury or other physical condition.

This authorization can be withdrawn by me at any time.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Printed Name



## Insurance Authorization Agreement

Your health insurance plan may now require “authorization” for some services (these may include one or all of the following: Chiropractic, Massage, Physical Therapy, and Acupuncture).

The number of annual visits for the above-mentioned services that are “allowed” by your plan may not have changed, however your insurance company now uses an outsourced (3<sup>rd</sup> party) company to decide what is “medically necessary” and, in turn, what they will pay for.

You may have received notification from your insurance company however such policies can be confusing and because we value your trust in us we want you to be aware of the reasons and processes involved.

### The Authorization Process

1. **Appointment with provider:** The information required by your insurance company to apply for authorization can only be gathered from a normal appointment with your provider.
  2. **Care Plan and Treatment:** you and your provider agree on the need for care and begin treatment.
  3. **Submission:** Vida will submit the required paperwork for you based on the information gathered at your in-office visit.
  4. **Authorization:** When authorization is granted it will specify (1) the number of visits and (2) the time frame allowed to use those. When the allowed visits are used or the time period expires a new authorization must be submitted.
- NOTE: this will apply regardless of the annual limits that your plan carries.

### Denials and Patient Responsibility

If a submission is not immediately approved it will go to “medical review”. It may take days or weeks for the insurance company to get back to us with a determination of approval or denial. If your case does go to **medical review** we will inform you so that you can make a decision to continue with care or wait until we receive the response.

Should you choose to receive care:

- Any visits that your insurance deems to lack “medical necessity” will become your financial responsibility. This is standard practice for any services rendered that are not covered by insurance. We always strive to keep you informed about where we are in the process of obtaining authorization.
- Due to the time sensitive nature of this process If you do not provide us with accurate insurance information and we are unable to obtain pre-authorization on your behalf then you may be responsible for the visit if we are unable to appeal.
- You cannot have two authorizations on file at the same time. If a past office has an active authorization file you will need to contact them to add a discharge date before the date of your first visit with us. If this is not done we will be unable to obtain pre-authorization and you will be responsible for any visits not approved.
- Please discuss with your provider if you believe you may have an authorization on file at a different clinic or have questions about this process. Any visits that your insurance does not pay for due to this issue will be your responsibility.

Vida continues to be a leader on researching and managing these new systems to get you the best care possible. Unfortunately, this new cost saving strategy by your insurance company simply makes it more difficult for you to utilize your insurance policy benefits.

Please let us know if you have any questions or concerns. We are here to help and do our best to make sure that you receive the care you need. Thank you.

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

Printed Name \_\_\_\_\_

**NOTE:** If you are one of the many health insurance customers who feel that this new policy is an unreasonable barrier to getting care we encourage you to make this known by contacting your employer (HR), your insurance carrier and the Insurance commissioner. All complaints to the commissioner must be investigated and will hopefully lead to a change in regulation.

Call or send your letter:  
Consumer Protection Services  
Office of the Washington State Ins. Commission  
P.O. Box 40256  
Olympia, WA 98504-0256  
Tel: (800) 562-6900





# HIPAA Agreement

(Notice of Privacy Practices Acknowledgement)

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations, such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed, to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Signature \_\_\_\_\_

Date: \_\_\_\_\_

Patient Name \_\_\_\_\_

Representative/Gaurdian Signature \_\_\_\_\_

Date: \_\_\_\_\_

Representative/Guardian Name \_\_\_\_\_

Office use only

I attempted to obtain the patient’s signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so, as documented below:

Date:

Initials:

Reason:





## HIPAA Agreement (Patient Copy)

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.

The Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. “HIPAA” provides penalties for covered entities that misuse personal health information.

As required by “HIPAA”, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions on relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to the requested restriction.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

Patient Copy



## INSURANCE/FINANCIAL POLICY

As a courtesy to you, we have verified your medical benefits with your insurance company.

### Financial Agreement:

- The quote you have received is *NOT* a guarantee of payment; it is only a quoted benefit by your insurance company.
- All co-payments and co-insurance portions due are expected at the time of service or by an authorized payment plan.
- Supplies and Nutritional Products are paid for at time of service and not billable to insurance.
- Office visits (initial exams and routine exams) WILL/ WILL NOT go toward your deductible.
  - CHIROPRACTIC: New Patient \$51-\$213.00 Established patient: \$38-\$146.00.
  - PHYSICAL THERAPY: New Patient \$74-\$120.00. Established patient: \$38-\$56.00.
  - NATUROPATHY: New Patient: \$43-\$182.00. Established Patient: \$26-\$116.00.
    - Insurance requires these exams for us to LEGALLY treat you.
- Please note, the Doctors perform and bill **“therapy”** as part of their Acupuncture and Chiropractic treatment, which may include: traction, myofascial release, stretching, kinesio-taping, balance training, active release therapy, manual therapy, and therapeutic exercises.
  - You should know:
    - These techniques are specialized and will help you reach your treatment goals.
    - They are NOT part of what is known as the chiropractic “adjustment”
    - These procedures cost b/w \$25-\$50 per treatment which WILL / WILL NOT go toward your deductible.
    - These codes may be combined with your Physical Therapy benefits.
- By giving us a copy of your insurance card, we are assuming you want Functional Health to bill services rendered at our clinic. If you do not wish to bill insurance, it is **your** responsibility to let us know.
- Most insurance policies have limitations on coverage. We will do our best to notify you when your maximum benefits have been reached so you can make new financial arrangements for the remainder of your care, but this is ultimately your responsibility.
- It takes about 4-6 weeks to receive payment notification from the insurance company.
- If you have **not** satisfied your deductible it is our policy to collect \$50 each visit until to help meet your deductible.
- If financial hardship exists, it requires Individual consideration. A complete financial disclosure with documentation of income will be required.
- **Massage therapy, Physical Therapy/Rehab, Acupuncture, ARNP cancellation policy:** We require 24 hours’ notice if you are unable to keep your appointment. Missed appointments will incur a \$35 charge.

**By signing this form, I understand that I am personally and financially responsible for any remaining balances not covered by my insurance company.**

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Printed Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

