Ballman CHIROPRACTIC

Our Success is Built on Results and Relationships

Date: _____

Name: _____ **Male** **Female** **Date of Birth:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone #: _____ **Phone Carrier:** _____

Email Address: _____ **Last 4 of SS#:** _____

Emergency Contact: _____ **Relation:** _____ **Phone #:** _____

Employer: _____ **Occupation:** _____ **Work #:** _____

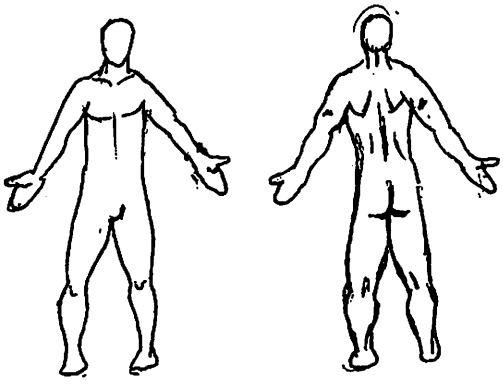
How did you hear about our office: _____

When did your condition begin? _____

Family Physician: _____ **Other doctors seen for this condition:** _____

Have you had the same or similar symptoms before: _____ Date of prior condition: _____

Mark Areas of Pain of figures Below:



List symptoms in order of severity Pain Level 0-10

(1) _____ _____

(2) _____ _____

(3) _____ _____

Is the pain: constant frequent occasional

Treatment Goals: _____

_____

Allergies: _____ **Previous Surgeries:** _____

Medications: _____

History of: Cancer Diabetes Heart Disease Stroke

Other serious Illness: _____

For Women: Are you pregnant: Are you taking Birth Control? _____

Health Insurance

Policyholder Name _____ Date of Birth _____

Plan # _____ ID # _____ Group #_____

Workers Compensation

Is your condition due to an Employment Related Injury? Yes ☐ No ☐ Have you reported it? Yes ☐ No ☐

Date of accident _____

Supervisor _____ Supervisor # _____

Auto Accident

Is your condition due to Automobile Accident? Yes ☐ No ☐ Date of accident _____

Auto Accident Insurance Name _____ Claim # _____

Adjuster Name _____ Phone #_____

Attorney Name _____ Phone #_____

INSURANCE INFORMATION, CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize BALKMAN CLINIC and their affiliated providers to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care, physical therapy, or any clinic services that they deem necessary in my case: I do hereby give my consent for the performance of conservative non-surgical treatment, including, but not limited to manipulation, physical therapy modalities, soft tissue massage and therapeutic exercises. I am aware there are possible risks and complications associated with these procedures, ranging from soreness to stroke. I understand there is no certainty that I will achieve benefits and acknowledge that no guarantee has been made regarding the outcome of these procedures. I am aware there are alternatives to these procedures, including medication and/or surgery. I further authorize them to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

I understand that if an insurance company initially pays for my treatment and later requests reimbursement from Balkman Chiropractic for any reason, I will be responsible for payment of my entire outstanding balance.

We invite you to discuss any questions you might have with us. The best health services are based on a friendly mutually understood relationship.

Patient's or Guardian's Signature _____Date _____

CONSENT TO TREAT A MINOR

I (we) being the parent, guardian or custodian of the minor being _____, age _____, do hereby authorize, request & direct Balkman Chiropractic, it's doctors and staff to perform examinations, diagnostic x-rays, laboratory tests, and any treatment that in their judgment, is deemed advisable or required.

It is the understanding of the undersigned that the physicians and their staff will have full authority from me as legal parent/guardian to continue with examinations, diagnostic tests, and treatments as will be needed while said minor shown above is under care in this office until legal age is attained.

As legal parent/guardian, I realize full responsibility for all charges and payments due.

Parent/Guardian or Custodian Signature _____ Date Signed _____

Witness _____

Balkman
CHIROPRACTIC
Our Success is Built on Results and Relationships

Balkman chiropractic is committed to providing exceptional customer service. Unfortunately, when one patient cancels without giving enough notice, they prevent another patient from being seen. Please call us at (479) 646-3984 by 2:00 p.m. on the day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 2:00 p.m. on Friday. If prior notification is not given, you will be charged $(25) for the missed appointment.

Please sign below to consent to these terms.

_____

Client Signature (Client's Parent/Guardian if under 18)

_____

Date

PATIENT OPTIONS ACCESS PROGRAM
FREE PATIENT ENROLLMENT AGREEMENT

As a patient, you are a participant in a Discount Managed Care Organization provided by Patient Options. There is NO FEE for patients to participate, and it is provided free to the public for those who are uninsured or otherwise underinsured. This Agreement and its terms and conditions, is between you and Patient Options. This Agreement is effective as of the date you sign below and are electronically enrolled at www.PatientOptions.org by your Provider and shall continue for a period of exactly one year (12 months) from the date of signature below. You will automatically be reenrolled for successive one year (12 month) periods unless request in writing.

There are no fees, dues, charges or other consideration required for participation.

DISCLOSURES:

· The Program provides discounts to you from contracted healthcare providers for services rendered;

· The Program participant is obligated to pay for all healthcare services directly as de facto 3rd party to provider but will receive a contractual discount from healthcare providers who have contracted with Patient Options;

·This is NOT insurance or a qualified policy under the Affordable Care Act or any state regulated program. Patient agrees this program and the discounts offered by contracted Providers are not available in instances where another third party insurance company is responsible for charges.

· Patient absolves provider of wrongdoing in the event the patient chooses to bill insurance for discounted services rendered under this Agreement;

· The name and address of the Discount Managed Care Organization is: Patient Options; 9435 Waterstone Blvd., Suite #140, Cincinnati, Ohio 45249. (866) 275-5633

This Disclosure and its Benefit descriptions represent the entire agreement between you and Patient Options and supersedes all other prior representations, statements, or written agreements between you and Patient Options.

I have read and agree to the terms and conditions set forth above:

Name:_____Signature:_____Date:_____

I have read and I refuse to participate:

Name:_____ Signature:_____Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____ acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of *Balkman Chiropractic Clinic,* which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received, or maintained by the practice.

_____ _____

Date Signature

_____

Printed Name

FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT

The Practice had made a good-faith effort to obtain an acknowledgement of _____'s receipt of our Notice of Privacy Practices. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgment of receipt for the following reasons: ☐**Patient Unavailable** ☐**Patient Physically Unable** ☐**Patient Unwilling**

In an effort to obtain the patients acknowledgement, the Practice has attempted to provide the patient with a Notice of Privacy Practices in the following manner:
☐**Personally** ☐**Mail** ☐**Phone Follow-Up** ☐**Other:**_____

_____ _____

Date Signature

_____

Printed Name of Doctor

Balkman Chiropractic Clinic

RELEASE OF INFORMATION TO PRIMARY CARE PHYSICIAN

This is a release of information to forward any or all records to your primary care physician.

_____ _____

Signature Date

Balkman Chiropractic Clinic LTD
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.

Our practice is dedicated, and we are required by applicable federal and state laws, to maintain the privacy of your health information. These laws also require us to provide you with this Notice of our privacy practices, and to inform you of your rights, and our obligations, concerning your health information. We are required to follow the privacy practices described below while this Notice is in effect. This Notice is effective as of 4/14/03, and will remain in effect until we replace it.

CHANGES TO NOTICE:

We reserve the right to change this Notice and the privacy practices described below at any time in accordance with applicable law. Prior to making significant changes to our privacy practices, we will alter this Notice to reflect the changes, and make the revised Notice available to you on request. Any changes we make to our privacy practices and/or this Notice may be applicable to health information created or received by us prior to the date of the changes.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

PERMITTED USES AND DISCLOSURES OF HEALTH INFORMATION:

A. **TREATMENT, PAYMENT, HEALTH CARE OPERATIONS:** You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for treatment, payment, and healthcare operations. Examples of these activities are as follows:
Treatment: We may use or disclose your health information to a physician or other healthcare provider, providing treatment to you.
Payment: We may use and disclose your health information to obtain payment for services we provide to you.
Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, and other business operations.

B. **AUTHORIZATIONS:** You may specifically authorize us to use your health information for any purpose or to disclose you health information to anyone, by submitting such an authorization in writing. Upon receiving an authorization for you in writing we may use or disclose you health information in accordance with that authorization. You may revoke an authorization at any time by notifying us in writing. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those permitted by this Notice.

C. **DISCLOSURES TO FAMILY AND PERSONAL REPRESENTATIVES:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. Such disclosures will be made to any of your personal representatives appropriately authorized to have access and control of your health information. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for you healthcare only if authorized to do so. In the event of your incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

D. **MARKETING:** We will not use your health information for marketing communications without your written authorization.

E. **USE OR DISCLOSURES REQUIRED BY LAW:** We may use or disclose your health information when we are required to do so by law, including for public health reasons (e.g., disease reporting). In some instances, and in accordance with applicable law, we may be required to disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

F. **PATIENT AND THIRD PARTY PROTECTION:** Only as permitted by law, we may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

G. **LAW ENFORCEMENT/NATIONAL SECURITY:** Under certain circumstances we may disclose health information relating to members of the Armed Forces to military authorities. Under certain circumstances we may also disclose health information relating to inmates or patients to correctional institutions or law enforcement personnel having lawful custody of those individuals. We may disclose health information in response to judicial proceedings and law enforcement inquiries as permitted by law and to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities.

H. **APPOINTMENT REMINDERS:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS:

A. **ACCESS TO RECORDS:** Upon submission of a written request to us, you have the right to review or receive copies of your health information, with limited exceptions. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may request that we provide copies in a format other that photocopies and we will use the format you request if it is readily available. We will charge you a reasonable cost-based fee for providing your health information in that format. If the information (excluding X-rays) is in contemplation of, preparation for, or use in any legal proceeding, we will charge a fee not to exceed $1.00 per page for the first five pages and $0.25 for each additional page. If you prefer, we will prepare a summary or explanation of your health information for a fee. Contact us using the information listed at the end of this Notice if you are interested in receiving a summary of your information instead of copies.

B. **ACCOUNTING OF CERTAIN DISCLOSURES:** Upon written request, you have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and other activities authorized by you, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12- month period, we may charge you a reasonable, cost-based fee for responding to these additional request.

C. **RESTRICTIONS AND ALTERNATIVE COMMUNICATIONS:** You have the right to request that we place and additional restrictions on our use or disclosure of your health information for treatment, payment and healthcare operations purpose. Depending on the circumstances of your request we may, or may not agree to those restrictions. If we do agree to your requested restrictions we must abide by those restrictions, except in emergency treatment scenarios. You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (e.g., at your place of business rather than at your home). Such requests must be made in writing, must specify the alternative means or location, and must provide satisfactory explanation how payments will be handled under the alternative means or location you request.

D. **AMENDMENTS TO RECORDS:** You have the right to request that we amend your health information. Such request must be made in writing, and must explain why the information should be amended. We may deny your request under certain circumstances.

E. **ELECTRONIC NOTICES:** If you receive this notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made or any decisions we may make regarding the use, disclosure, or access to your health information you may complain to us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file such a complaint upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. Please direct any of your questions or complaints to:

Contact: Kyle Jarnagin, D.C.
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Fax: 479-646-2129
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