WELCOME TO OUR OFFICE!

Discover Chiropractic Healthcare P.C.

We are very pleased that you are here today. If you have any questions concerning our policies, forms, or procedures, just ask. It is our pleasure to serve you.

Our Privacy Practices & HIPPA

In our office, all health information is considered confidential and we are careful about how we use it. This notice describes how your health information may be used and disclosed and how you can get access to this information. Please read about your health information and let us know if you have any questions.

We may share your health information to:

- Treat you
- Collect Insurance Payments
- Thank you for referring other patients
- Discuss your case with family

We may use your health information for:

- Health and safety
- Reporting to law officials
- Reporting victims of abuse
- Court hearings and filings
- Reporting to worker's compensation

You have the right to:

- Request a copy of your health record
- Request a list of whom we share your health information with
- Ask us to limit the information we share
- Advise our management if you believe your privacy rights have been violated
- Request confidential communications
- Amend your protected health information

I understand and agree to the following:

- The privacy practices have been satisfactorily explained to me and I have received a copy of the Notice of Privacy Practices or had the opportunity to receive a copy.
- I understand the purpose of today's visit.
- The doctor(s) may use my confidential health information in the manner previously described.

Printed Patient/Guardian Name _____ Patient/Guardian Signature _____ Today's Date _____

7343 Park Avenue Allen Park, Michigan 48101 Phone: (313) 582-1040 Fax: (313) 582-3642

NEW PATIENT INFORMATION

* Optional

Discover Chiropractic Healthcare P.C.

Welcome to our office! Please provide us with your updated personal information so we can complete your file.

First Name: _____ Middle Initial: _____ Last Name: _____

Preferred Name: _____ Preferred Phone Number: Home Work Cell

*Home Phone :(_____) _____ Cell Phone: (_____) _____ *Work Phone: (_____) _____

Occupation: _____ Employer: _____

Email Address: _____@_____

Home Address: _____

City: _____ State: _____ Zip: _____

Birth Date: _____ / _____ / _____ Social Security Number: _____

What is the purpose of your visit today? _____

*Marital Status: M S W D *Smoking Status: ☐ Never, ☐ Current, ☐ Former

*How did you hear about us? Who referred you? _____

In the case of an EMERGENCY who may we contact? _____ Phone: _____

Primary Care or Referring Physician: _____ Phone: _____

Did you sustain an injury at work? YES / NO Are your injuries accident related? YES / NO

Have you had previous chiropractic care? If yes, Doctor: _____ Last Visit: _____

Is the reason for your visit today regarding the same condition/injury? _____

*Reason for leaving previous Chiropractic Physician: _____

If you are insured under your spouse's policy, we need their information:

Spouse's Name: _____

Birth Date: _____ / _____ / _____ Social Security Number: _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information provided to me in the patient information package and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature: _____ Date: _____ / _____ / _____

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OFFICE FINANCIAL POLICY

Discover Chiropractic Healthcare P.C.

Upon entering our office, your insurance coverage should be verified. When your coverage is presented, you ***should not*** *in any way interpret it as a* ***guarantee of payment*** on the part of your insurance company. It must be fully understood that *your contract is between you and your insurance company*, and you are ***fully responsible*** for any amount not paid by your insurance.

1) Since taking your insurance on assignment we have to wait for payment, this courtesy may be revoked at any time if circumstances warrant it.

2) If you discontinue care, the balance of your account is due and payable in full immediately. If your insurance does make payment, a refund will be made to you for the difference between the payment and your account balance.

3) Your insurance is expected to pay within 30 days. Claims not paid or responded to by your insurance company within 60 days will be transferred to your patient balance for immediate payment, and upon receiving an insurance payment, reimbursement to you will be made for the difference between the payment and your account balance.

4) We will continue to bill your insurance as a courtesy to you as long as you are receiving chiropractic care in this office.

5) You are required to sign an *"Authorization of Assignment"* form, and any other assignment documents required by your insurance company on your first visit.

6) You are required to pay your percentage of your bill at the conclusion of each office visit. This percentage is referred to as your *"co-pay"*. Your co-pay will be explained to you on your first office visit. If your co-pay percentage is not verified on your first visit, you will be required to make a payment towards your total charges for that office visit. Such payments will then be credited to your account. Any overpayment on your part will be refunded to you in the amount of the difference between the sum of your payments, and your account balance.

7) Our office will in no way guarantee that your insurance company will pay, and our office will not enter into a dispute with an insurance company over your claim. This is your responsibility and obligation.

8) ***SERVICE CHARGES:***

a) A returned check fee of $50.00 will be applied to an account in which a NSF check is submitted for payment.

b) Accounts with **balances over one hundred and twenty (120) days** will be **referred to an outside collection agency** for processing which will include a **collections fee of 40%.**

c) Monthly statements are processed and mailed the first week of each month. You are expected to remit payment when such statements are received indicating a balance owing.

I am in complete understanding of the previously stated terms and conditions, and any questions I may have concerning such stated policies have been answered. I hereby acknowledge, and agree to said policies pursuant to my treatment with this office.

_____ _____ / _____ / _____

Patient Signature Date

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PATIENT INSURANCE NOTICE

Discover Chiropractic Healthcare P.C.

Due to the constant changes in insurance, it has become harder to interpret each individual's policy. Although we try to stay aware of these changes, *it is not possible to guarantee them.*

It is *your responsibility* to know your individual coverage! Please do not get frustrated at us if your insurance does not cover all of our services. Remember, your insurance is between you and your insurance company, not between the insurance company and our facility.

Most insurance policies have different exclusions and most policies have *deductibles, co-insurance and co-pays* that must be met by you. *It is the law!*

_____ _____ / _____ / _____

Patient Signature or responsible party Date

7343 Park Avenue Allen Park, Michigan 48101 Phone: (313) 582-1040 Fax: (313) 582-3642

AUTHORIZED PATIENT ASSIGNMENT

Discover Chiropractic Healthcare P.C.
7343 Park Avenue, Allen Park, Michigan 48101.
Phone: (313) 582 – 1040 Fax: (313) 582-3642

PATIENT ASSIGNMENT

I hereby authorize my Attorney and/or Insurance Company to pay by check, made out and mailed directly to Discover Chiropractic Healthcare P.C. and Nicholas S. Griffiths D.C. the professional or medical expense benefits allowable; otherwise, payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this office.

RELEASE OF INFORMATION

I authorize this office to release any information pertinent to my case to any insurance company, adjuster, collections, and/or attorney involved in this case, and hereby releases Discover Chiropractic Healthcare P.C. and Nicholas S. Griffiths D.C. of any consequence thereof.

FINANCIAL RESPONSIBILITY

I agree to be financially responsible for all charges incurred at Discover Chiropractic Healthcare P.C. including my *deductible, co-payment, processing fees and any other services rejected by my insurance company.*

A photocopy of this agreement shall be considered as effective and valid as the original.

_____ _____ / _____ / _____

Patient Signature Date

INFORMED CONSENT

Discover Chiropractic Healthcare P.C.

When a patient seeks chiropractic health care and we accept a patient 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 patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Initial

Vertebral Subluxation: A misalignment *(hypo-mobility)* of one or more of the 24 vertebrae in the spinal column including the pelvis and sacrum which causes alteration of joint function and mobility. This directly causes irritation and inflammation of the surrounding soft tissue, ligaments and muscles. When this occurs the vertebral joint heals wrong, pinches and irritates the spinal nerve, which then elicits local and/or radicular pain. These pinched and irritated nerves then cause spinal muscles to tighten up and spasm which further decreases joint function. The muscle spasms then cause immediate scar formation surrounding the spinal joint with strands of fibrous tissue. The muscles therefore cannot function correctly and the spinal subluxation continues to grow weaker. When this cascade of events occurs and goes uncorrected for a period of time compensation and adaptation occurs at the original site of involvement. In time, the entire biomechanics of the spine must adapt to the subluxated area and the process of spinal decay and degeneration (arthritis) begins to spread throughout the spine.

Initial

Adjustment: An adjustment is the specific application of force(s) by hand or instrumentation directly to established vertebral, pelvic and sacral subluxations to reduce and correct the spinal misalignment or hypo-mobility which will allow for normal joint function and eliminate the consequences of the vertebral subluxation complex.

Initial

Associated Risks: The *American Journal of Medicine* reported on studies that investigated the risks between spinal manipulation and other treatments for the same conditions. For instance, one analysis concluded there was no evidence that non-steroidal anti-inflammatory drugs were any more effective than spinal manipulation, but the risk of serious complications or death was between 100 and 400 times greater with NSAID's. In another review, estimates of serious gastrointestinal events from NSAID's were 1/1000, whereas complications of cervical manipulations were 5 to 10 per 10 million treatments

Additional studies all found spinal manipulation, when performed by a qualified, licensed DC, is extremely safe and effective. In fact, a Duke University study said that spinal manipulation "has a very low risk of serious complications." However, some known complications related to spinal manipulation include but not limited to sprains/strains of the rib cage, dislocations, and fractures, strokes, paralysis, vertebral artery dissection, death and vertebral joint inflammation/irritation of surrounding soft tissues and joint capsules. If you have questions or concerns regarding any associated risks, please advise the staff or doctor before proceeding with care.

Initial

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-muscular-skeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Initial

I hereby request and consent to the performance of chiropractic manipulation or adjustments and other chiropractic procedures, including various modes of physical therapy or physical medicine procedures, and diagnostic x-rays, on me (or on the patient named below for whom I am legally responsible) by Dr. Griffiths, a doctor of chiropractic, and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as backup for Dr. Griffiths.

I have had an opportunity to discuss with Dr. Griffiths and/or with other office or clinic personnel the nature and purpose of chiropractic manipulations or adjustments and other procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all possible risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time, based upon the facts then known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition. I therefore accept chiropractic care on this basis.

_____ _____ / _____ / _____

Patient Signature Date

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