The Good Life Chiropractic

Healing is an inside job.

Sue Mullen, DC

Welcome! This information is important; please print. *Today's Date:* _____

Patient Name _____ (First / MI / Last)

Address _____ Hm# (_____) _____-_____

City _____ State _____ Zip _____ Cell# (_____) _____-_____

Social Security# _____-_____-_____ Email Address _____

Date of Birth _____/_____/_____ Age _____ Sex: ❑M ❑F Marital Status: ❑S ❑M ❑W ❑D

Employer/School _____ (Name / Address / City / State / Zip)

Occupation _____ Wk Phone# (_____) _____-_____

Children Names and Ages _____

Who referred you to our office? _____

Have you ever been to a chiropractor before? ❑No ❑Yes If so, when? _____

Do you have symptoms? ❑No ❑Yes If so, what are they and how have they affected your life? _____

_____

Are you currently under any Doctor's care? ❑No ❑Yes

- Is this work related? ❑No ❑Yes If so, have you reported it to your employer? ❑No ❑Yes
- Is this related to an auto accident? ❑No ❑Yes Date of Accident: _____

❖❖ **Females:** Are you pregnant? ❑No ❑Yes ❑ Not sure

2620 Telegraph Avenue Berkeley, CA 94704 T: 510.356.4048 F: 510.356.4137

FINANCIAL POLICIES

INSURANCE

It is the policy of this office that you pay for your first visit in full at the time of the visit. If you have health insurance that you believe may cover chiropractic in this office, we will verify your insurance coverage for you. Once your eligibility and coverage is determined we will file all insurance claims for you to the extent that your policy permits.

You are responsible for 100% of the cost of services, supplements, and supplies even if your insurance does not cover 100%. That means if insurance covers a certain amount of the cost, you agree to cover the actual difference. Insurance verification is no guarantee of actual coverage. Unless you are with Blue Shield, you agree to pay the full cost of services up front and be reimbursed to the extent permitted by your policy. The clinic does not promise that an insurance company will pay the fees as charged. Therefore the clinic will not enter into a dispute with an insurance company for reimbursement or the amount of reimbursement. This is the patient's obligation.

We are in network with Blue Shield. If you are insured by Blue Shield, you must pay your estimated deductible, co-payment and non-covered supplements, supplies, and services at the time they are rendered. Since verification is no guarantee of coverage, the actual amount for which you are responsible, as determined by Blue Shield, may vary from what we estimated based on verification.
Initials_____

NON-INSURED

We request 100% of the first visit be paid at the time of the first visit. All future visits must be paid for at the time of service.

If your financial situation requires special arrangements, please speak with the Financial Coordinator. **Initials**_____

WORKERS' COMPENSATION

We are not accepting workers' compensation cases at this time.

MEDICARE

Dr. Mullen is a Non-Participating Provider with Medicare and does not accept assignment. However, we do bill Medicare for patients with Medicare Part B who wish us to. Medicare does require that you pay for X-rays, examinations, supplements, supplies, physical therapy and any other non-covered services, and therefore you will be asked to pay for these services at the time you receive them. You will also be required to pay an annual deductible and small co-payment. If you have a supplemental insurance policy that covers chiropractic we will bill them for you if Medicare does not.

GENERAL

If the Doctor determines that services are necessary, all charges are payable when rendered.
What form of payment will you use? □ Cash □ Check □ MC/Visa

If you have insurance that covers chiropractic care, we can assist you in filing your claims.
Name of Insurance Company_____
Policy #_____ Claim / Group # _____

*Any outstanding balances past 30 days will be charged interest @ 1.5% monthly (18% annually) **Initials**_____
*Missed appointments not rescheduled 24 hours prior to your scheduled time will be charged the normal office visit fee. (Insurance carriers will not cover this fee. **Initials**_____

Print Patient's Name_____Patient's Signature_____ Date_____

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all 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 interests.

I further understand that chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if you wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatory, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

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 to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient (print)_____

Signature of Patient: _____ **Date:**_____

Name of Guardian/Parent (print) _____ Relationship: _____

Guardian/ParentalSignature:_____ Date:_____

Doctor of Chiropractic Name (print) _____

Signature of Doctor of Chiropractic: _____ **Date:**_____

TERMS OF ACCEPTANCE

In order to provide for the most effective healing environment, most effective application of chiropractic procedures and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following points regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.

B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from the normal spinal structures and configurations that interfere with normal nerve processes.

C. The chiropractic adjustment process, as defined in the "law of this jurisdiction" involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one-million times each day by doctors of chiropractic in the United States alone.

D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If, during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist according to the initial indications of the need.

E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for the care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.

F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic.

G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration or cost, in what we work to maintain as a supporting, open environment.

I, _____ have read and fully understand the above statements.
Print Name

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

Signature: _____ Date: _____

Please see other side →

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review this carefully

Our office is committed to maintaining your privacy. This includes information about your health condition and the treatment you receive in our office. This notice will tell you about the ways we may use and share information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

We will not use or disclose your medical information for any purpose not listed below without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: In order to provide you with the health care you require, The Good Life Chiropractic will provide your medical information to those health care professionals who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: The Good Life Chiropractic may use and disclose your medical information to be reimbursed. We may also need to tell your insurance company about your treatment you are going to receive so that they can determine whether or not it will cover the treatment.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operation. This might include measuring and improving quality, evaluating the performance of employees, conduction training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

REFERRAL BOARD: The Good Life Chiropractic has a practice member WALL OF FAME with pictures and testimonials that can be seen by anyone who enters the office. Yours will be posted only upon receiving your written consent.

APPOINTMENT REMINDER: The Good Life Chiropractic may contact you to remind or reschedule an appointment. The Good Life Chiropractic uses the following appointment reminders:

a) Postcard mailed to you at the address provided by you.

b) Telephoning your home and leaving a message on your answering machine or with the individual answering the phone.

FACILITY SET-UP: Our examination room is private but without a door and we have an open adjusting area. Staff and doctors will maintain policies to ensure privacy, but there may be some inadvertent disclosure to others in the facility at the same time. If there is private information that you need discussed, please request to have such discussions in a private room.

X-RAY: View boxes are located in the examination and adjusting areas. Staff and doctors will maintain policies to ensure privacy, but there may be some inadvertent disclosure to others in the facility at the same time. If there is private information that you need discussed please request to have such discussions in a private room.

FAMILY/FRIENDS NOTIFICATION: The Good Life Chiropractic may disclose medical information to a person who is directly relevant to your care or the payment for your care. This may include your family member, other relative, a close personal friend, or any other person identified by you. The Good Life Chiropractic may also use or disclose your medical information to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, your location, general condition, or death.

Please see other side

YOUR INDIVIDUAL RIGHTS

YOU HAVE A RIGHT TO:

Look at or get copies of your medical information. You may request that we provide copies in a format other than photocopies. We will use the forms you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by contacting the office manager. You may also request access by sending a letter to the contact person listed at the end of this notice. You may request copies; however, we will charge you $1.00 for each page, and postage if you want the copies mailed to you.

Receive a list of all the times we or our business associates share your medical information for any purpose other than treatment, payment, health care operations, or other specific exceptions.

Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).

You may request in writing that we communicate with you about your medical information by different means or to different locations. You may request that we change your medical information. We may deny your request and provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name and to include the changes in any future sharing of that information.

You have the right to a copy of this notice upon request in writing to the Privacy Officer at The Good Life Chiropractic.

OUR LEGAL DUTY

LAW REQUIRES US TO:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

WE HAVE THE RIGHT TO:

1. Change our privacy practices and terms of this notice at any time, provided that law permits the changes.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information we keep, including information previously created or received before the changes.

NOTICE OF CHANGE TO PRIVACY PRACTICES:

Before we make any important change in our privacy practices, well will change this notice and make the new notice available upon request.

ACKNOWLEDGEMENT:

I have received a copy of the Notice of Privacy Practices and had an opportunity to review it.

Print Name_____ **Date of Birth** _____/_____/_____

Signature_____ **Date**

_____