

# A Better Way

FOR HEALTH

Thank you for choosing **A Better Way for Health**. We will work hard to see that you get the best healthcare and services available. Hopefully, we will become your healthcare partner. To achieve this, we will need the following commitment from you:

1. Payment the day of service. We accept cash, check, MC and Visa.
2. Payment of deductibles or co-pays the day of service.
3. Current personal and insurance information.
4. Assignment of insurance benefits when applicable.

Furthermore, as a patient of A Better Way for Health:

1. I understand having insurance does not guarantee payment of services.
2. I can request a predetermination of my benefits prior to any treatment. (Verification of benefits is not a guarantee of payment)
3. I am ultimately responsible for understanding my financial obligation.

Here is our promise to you:

1. You will always receive courteous and friendly attention.
2. We will submit claims to your insurance as a courtesy to you.
3. We will work hard to keep you informed.
4. We welcome any questions you have regarding your treatment.
5. If we cannot help you, we will find someone who can.

Thanks for your confidence. We look forward to providing you the best healthcare along with friendly and courteous service.

I have read everything above and understand my obligation to A Better Way for Health for all services provided to me.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



<b>Patient Information</b>		
Last Name:	First Name:	Middle Initial:
Gender:	Marital Status:	
Street Address:		
City:	State:	Zip:
Date of Birth:		
SS#:		
Best Contact Phone:		
Work Phone:	Cell:	
E-Mail:		
Employer:		
<b>Referred By:</b>		
<input type="checkbox"/> Phone Book	<input type="checkbox"/> Walk-In	<input type="checkbox"/> School Promo
<input type="checkbox"/> Employee Referral _____	<input type="checkbox"/> Other Physician	<input type="checkbox"/> BC/BS Web
<input type="checkbox"/> Patient Referral _____		<input type="checkbox"/> Non Patient
<b>Emergency Contact and #:</b>		

<b>Current Health Conditions</b>
Health related problem you are having today :
Other Doctors seen for this condition:
Type of treatment: _____ Results: _____
Onset Date: _____ Has this condition occurred before: <input type="checkbox"/> Yes <input type="checkbox"/> No
Is condition: <input type="checkbox"/> Job Related <input type="checkbox"/> Auto Accident <input type="checkbox"/> Home Injury <input type="checkbox"/> Fall <input type="checkbox"/> Other
Date of accident: _____
Have you made a report of your accident with your employer: <input type="checkbox"/> Yes <input type="checkbox"/> No
Current Medications:
Do you wear a shoe lift: <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you suffer from any condition other than that which you are now consulting us:
Major surgery/operations:
Other Hospitalizations:
Major accidents or falls:
Previous Chiropractic Care: <input type="checkbox"/> None
<input type="checkbox"/> Doctor's Name and approx. date of last visit:
What would you like to achieve from Chiropractic Care?

## REVIEW OF SYSTEMS

Below is a list of symptoms that may seem unrelated to the purpose of today's appointment but must be answered carefully as these problems can affect your overall course of care.

Check	Diseases You Have Had:	Office Use Only (do not write in this area)
<input type="checkbox"/>	Diabetes	
<input type="checkbox"/>	Cancer	
<input type="checkbox"/>	Heart Disease	
<input type="checkbox"/>	Thyroid	
<input type="checkbox"/>	Lumbago	
<input type="checkbox"/>	Eczema	
<input type="checkbox"/>	Arthritis	
<input type="checkbox"/>	HIV	
<input type="checkbox"/>	Mental Disorders	
<b>A.</b>	<b>Musculo-Skeletal</b>	
<input type="checkbox"/>	Low back Pain	
<input type="checkbox"/>	Shoulder Pain	
<input type="checkbox"/>	Neck Pain	
<input type="checkbox"/>	Arm Pain	
<input type="checkbox"/>	Joint Pain/Stiffness	
<input type="checkbox"/>	Difficulty Walking	
<b>B.</b>	<b>Nervous System</b>	
<input type="checkbox"/>	Nervous	
<input type="checkbox"/>	Numbness	
<input type="checkbox"/>	Paralysis	
<input type="checkbox"/>	Dizziness or Fainting Spells	
<input type="checkbox"/>	Forgetfulness	
<input type="checkbox"/>	Stress	
<input type="checkbox"/>	Seizures or Convulsions	
<input type="checkbox"/>	Cold/Tingling Extremities	
<b>C.</b>	<b>Genitio-Urinary</b>	
<input type="checkbox"/>	Bladder Trouble	
<input type="checkbox"/>	Painful Urination	
<input type="checkbox"/>	Discolored Urine	
<b>D.</b>	<b>C-V-R</b>	
<input type="checkbox"/>	Chest Pain	
<input type="checkbox"/>	Shortness of Breath	
<input type="checkbox"/>	Difficulty Breathing When Lying Down	
<input type="checkbox"/>	Blood Pressure (High/Low)	
<input type="checkbox"/>	Irregular Heartbeat	
<input type="checkbox"/>	Racing Heart	
<input type="checkbox"/>	Stroke	
<input type="checkbox"/>	Heart Problems	
<input type="checkbox"/>	Congestion/Lung Problems	
<input type="checkbox"/>	Emphysema	
<input type="checkbox"/>	Coughing Spells	
<input type="checkbox"/>	Coughing Blood	
<input type="checkbox"/>	Varicose Veins	
<input type="checkbox"/>	Swelling in Feet or Ankles	
<input type="checkbox"/>	Pain in Leg After Walking	

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

**REVIEW OF SYSTEMS (2)**

<b>Check</b>		Office Use Only
<b>E.</b>	<b>EENT</b>	(do not write in this area)
	Headaches	
	Vision Problems (Blurred/Double/Glaucoma)	
	Dental Problems	
	Clicking Jaw/TMJ	
	Neck Lumps or Swelling	
	Thyroid Problems (Hyper/Hypo)	
	Sore Throat/Hoarseness	
	Difficulty Swallowing	
	Earaches	
	Hearing Problems	
	Stuffed Nose/Nose Bleeds	
	Allergies	
<b>F.</b>	<b>Gastro-Intestinal</b>	
	Poor/Excessive Appetite	
	Excessive Thirst	
	Frequent Nausea	
	Vomiting	
	Heartburn	
	Gas/Bloating	
	Diarrhea/Constipation	
	Hemorrhoids	
	Black/Bloody Stool	
	Liver Problems	
	Gall Bladder Problems	
	Weight Trouble	
	Abdominal Cramps/Colitis	
<b>G.</b>	<b>Female Gender Specific</b>	
	Menstrual Irregularity	
	Menstrual Cramps	
	Date of last period _____	
	Are You Pregnant? Yes ___ No___	
	Breast Pain/Lumps or Masses	
	Frequent Vaginal Infections	
<b>H.</b>	<b>Male Gender Specific</b>	
	Chronic or Recurrent Infections	
	Lumps or Masses in Penis or Testicles	
<b>I.</b>	<b>General Health</b>	
	Unexplained Weight Loss	
	History of Diabetes	
	Loss of Sleep	
	Fatigue	
	Fever	
<b>J.</b>	<b>Please indicate amount of intake of the following:</b>	
	Tea_____ Coffee_____ Alcohol_____	
	White Sugar_____ Cigarettes_____	

The following family members have the same or similar problems as I do: \_\_\_\_\_

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

## TERMS OF ACCEPTANCE AND CONSENT FOR CARE

This Document Constitutes Informed Consent For Chiropractic Care

The purpose and goal of Chiropractic is to restore and maintain the integrity of the spinal cord and its nerve roots. These vital nerve pathways are housed in and protected by the bones of the spine. Misalignments of the bones of the spine, which interfere with the function of the nerve pathways, are called vertebral subluxations. Chiropractors locate, analyze, and correct these vertebral subluxations by specific adjustments of the spine. The Chiropractic examination and adjustment are not substitutes for other types of health care, just as other types of care do not take the place of Chiropractic. Being free of subluxations is complimentary to anything that enhances the body's holistic integrity and state of health. X-Rays may be taken, which the doctor may consider necessary in the course of care.

I, (print your name) \_\_\_\_\_, have read the above, understand it fully, and undertake Chiropractic care on this basis.

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

### COMPLETE IF PATIENT IS A MINOR

Patients Name: \_\_\_\_\_

I, (print custodial name) \_\_\_\_\_, being the parent or legal guardian of the after mentioned minor have read and fully understand the above terms of acceptance and hereby grant permission for said be minor to receive Chiropractic care.

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

### FEMALE PATIENT

To the best of my knowledge, I am not pregnant and have been notified and advised that X-Rays may/can be hazardous to an unborn child. I deny pregnancy.

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

### AUTHORIZATION TO RELEASE INFORMATION AND TO PAY BENEFITS TO A BETTER WAY CHIROPRACTIC

I hereby authorize my physician/clinic to release any information acquired in the course of my examination or treatment as deemed necessary. I hereby authorize payment directly to my physician/clinic.

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

### TO WHOM IT MAY CONCERN:

I hereby authorize and direct you \_\_\_\_\_, my Attorney OR Insurance Company, to pay directly to A Better Way for Health such sums as may be due and owing them for services rendered me by reason of accident and be reason of any other bills may be due them, and to withhold such sum from any settlement on my behalf as may be necessary for adequate protection of them. This is to act as an assignment of my rights and benefits to the extent of their services provided. A photocopy serves as good as an original.

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

## **Late Cancellation/No Show Policy**

At A Better Way for Health we pride ourselves on our professional and experienced staff. Our staff is scheduled according to the needs of the patients.

Because we have limited appointment times to accommodate all of our patients, it is imperative that you are punctual for your scheduled appointments.

We understand that emergencies and unexpected events happen. Please call us to reschedule your appointment for a more convenient time and your late fee will be waived. Otherwise, we will automatically charge \$15.00 to your account for all No Shows.

Name: \_\_\_\_\_  
(please print)

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

## **Notice of Privacy**

As required by the  
Health Insurance Portability  
and Accountability Act (HIPPA)

**How your health  
information  
May be used in our  
office.**

### To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between the chiropractor, chiropractic assistant, and office staff. In addition, we may share your health information with referring doctors or other health care professionals providing you different types of care.

### To Obtain Payment

We may include your health information with an invoice used to collect payment for care you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information

### To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in the training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

### Patient Reminders and Educational Material

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment.

Additionally, we may contact you to follow up on your care, inform you of care options or services that may be of interest to you or your family. Communications are an important part of our philosophy of partnering with our patients to be sure they receive the best chiropractic care we can provide. They may include newsletters, postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders). Our office may send out patient newsletters and other educational materials which HIPPA defines as being marketing tools. While this practice may be classified as marketing, we would never use your personal information for any kind of advertising without your express written permission. Occasionally in our newsletters we may list a patient's name to thank them for a referral, wish them a happy birthday, welcome them to the office or congratulate them for a positive life achievement.

### Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect, or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

### Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

### Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our very best judgment when sharing your health information to those participating in providing your care.

### Coroners, Funeral Directors and Medical Examiners

We may be required by law to provide information to coroners, funeral directors and

medical examiners for the purpose to determining a cause of death and preparing for a funeral.

### For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain circumstances, if you are the victim of a crime or in order to report a crime.

### Chiropractic Research

Advancing scientific knowledge often involves learning from the careful study of the health histories of prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements and approval of an Institutional Review Board.

### Authorization to Use or Disclose Health Information

Other than what is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your authorization. You may revoke that authorization in writing at any time.

### Patient Rights

The Health Insurance Portability and Accountability Act is careful to describe that you have the following rights related to your health information.

### Restrictions

*You have the right* to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction requests from our patients.

### Confidential Communications

*You have the right* to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

### Amend Your Health Information

*You have the right* to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as

our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change. Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

### Inspect and Copy Your Health Information

*You have the right* to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may charge you a reasonable fee to duplicate and assemble your copy.

### Documentation of Health Information

*You have to right* to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health care operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

### Request a Paper Copy of this Notice

*You have the right* to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

### Patient Acknowledgment

Please list patient and any dependant name(s)

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If you wish to exempt yourself from any of the above policies, you may do so by submitting your request in writing. To acknowledge the above policies, please sign below. Thank You.

Signature: \_\_\_\_\_

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