Protect Your Spine

NEW PATIENT INFORMATION

First Name: _____ M.I._____ Last Name: _____ D.O.B._____ Age_____ Sex: M / F

Address: _____ City:_____ State_____ Zip:_____

Phone: Home _____ Cell:_____ Work:_____

Email Address: _____ Emergency Contact Name / Number:_____

SSN:_____ Marital Status: ❑ Single ❑Married ❑ Divorced ❑ Separated ❑ Widowed

Primary Care Physician:_____ Phone:_____ Fax:_____

Any Previous Chiropractic Care? ❑ Yes ❑ No Last Adjustment Date: _____ Is this a Motor Vehicle or Work injury? ❑Yes ❑No

Please list the current health complaints and / or other reasons for consulting our office today in order of priority below.

1. _____

2. _____

3. _____

Sports / Hobbies: _____

Medications you are currently taking: _____

❑ I am not pregnant at this time; I hereby consent to have the X-ray Procedure if necessary ❑ Pregnant ❑ Not Sure Initial: X_____

Insurance Information: ***(Do not complete the section below if you do not have insurance)***

Policy Holder (Name):_____ Relation to Patient_____

Policy Holder's DOB:_____ Policy Holder's SSN: _____

Insurance Company: _____ Policy #: _____ Group #: _____

Additional Insurance Information (Secondary Insurance):

Policy Holder (Name):_____ Relation to Patient_____

Policy Holder's DOB:_____ Policy Holder's SSN: _____

Insurance Company: _____ Policy #:_____ Group #:_____

How did you hear about us? ❑ Google ❑ Facebook ❑ Twitter ❑ Instagram ❑ Other_____

I authorize the release of any information concerning my (or my child's) health care and treatment for the purposes of evaluation and administering claims of insurance benefits. I also hereby authorize payment of insurance benefits, otherwise payable to me directly, to Protect Your Spine. We will file a claim with your insurance company for services provided. In the event of non-payment you will be responsible for the charges incurred today.

X_____ Date: _____

(Signature of patient or parent / guardian of minor)

Protect Your Spine

AUTHORIZATION FOR RELEASE OF INFORMATION

I herby authorize *Protect Your Spine* and it's staff members to disclose the following information from the healthcare record of:

Patient Name: _____ D.O.B. _____ Phone: _____

Address: _____ City: _____ State _____ Zip: _____

This information is to be disclosed to:

Business Name: _____ Contact Name: _____

Address: _____ City: _____ State _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

Information to be disclosed:

❑ Office Notes ❑ X-Ray Reports ❑ MRI Report or CD ❑ Complete Health Records

❑ Other: _____

Special instructions: _____

_____

_____

_____

- ✓ **I understand that the authorization is valid for 12 months after the date signed, unless canceled by me in writing.**
- ✓ **I have read and understand the above statement and do expressly and voluntarily consent to disclosure of the above information to those persons or business named above.**
- ✓ **I herby release *Protect Your Spine* and its staff members from all legal responsibility or liability that may arise from the release of these healthcare records.**

X _____ Date: _____

(Signature of patient or parent / guardian of minor)

Protect Your Spine

TERMS OF ACCEPTANCE

When a person seeks chiropractic care, and when a chiropractor accepts a patient for such care, it is essential that they both are seeking and working towards the same goals. Chiropractic has one goal. It is therefore important that you understand the goal and our means to attain it. In this way there will be No confusion, misunderstanding, or disappointment.

1. You must realize that chiropractic is NOT a substitute for medical treatment of any kind, in any way, for any reason. Also NO statement of the Chiropractor is intended as a medical diagnosis and should not be confused as such. Patients usually want to get rid of whatever ailments, symptoms or conditions are bothering them. This however, is NOT the goal of the Chiropractor. Chiropractic is not intended to be a treatment of the symptoms of a medical condition or to treat the cause or causes of a medical condition.

2. The purpose of chiropractic is to restore and maintain the integrity of the spinal cord and its nerve roots. These vital nerve pathways are housed and protected by the bones of the spine. Tiny misalignments of the vertebrae and bones of the spine, which interfere with the function of these nerve pathways, are called subluxations. Subluxations come from many causes and prevent various organs, glands and tissues from functioning properly.

3. By means of a chiropractic adjustment, subluxations are corrected (reduced), thus, the normal nerve function restores itself. The goal of chiropractic is to adjust vertebral subluxations for the purpose of allowing the proper transmission over nerve pathways so that every part of the body may have a proper nerve supply at all times. This allows the innate healing ability of the body to work at maximum efficiency.

4. With proper nerve supply health improves. In some, symptoms clear up quickly. In others, the process is slower, and in some, it is only partial or not at all. Regardless of what the disease is called, the chiropractor does not offer to heal or even treat it, nor does he offer advice regarding the treatment of disease. His only goal is to allow the body to do its job. His only means is the correction of vertebral subluxation. He promises no cure from and offers no treatment of disease.

The information we receive from you is important. We ask only that which is necessary to Protect Your Spine. For this reason, please fill out this form completely and to the best of your ability. If you have any questions or there is any information you feel we should know, please mention it to the doctor.

I **(Print Name)**_____, have read the information above, understand it fully, and undertake chiropractic care on this basis.

X_____ Date: _____

(Signature of patient or parent / guardian of minor)

Protect Your Spine

TO ALL PATIENTS

Since 08/21/96, Health Insurance Portability and Accountability Act (HIPAA) has impacted all areas of the health care industry and was designed to improve the efficiency of health care by standardizing the exchange of administrative and financial data, and to protect the privacy, confidentiality and security of health care information. A major concern in the law was the security and privacy of electronic health records and their transmission between health care entities. The securities consist of more than just firewalls. Organizations must ensure the confidentiality and integrity of their health records, and transmission of data must be authenticated and have the property of nonrepudiation. Additionally, security policies and procedures must be documented and implemented.

Protect Your Spine has a policy requiring all employees to read and sign a confidentiality agreement. This agreement states that the employee understands that we process confidential data, and that the employee agrees not to directly or indirectly disclose any information in an inappropriate manner. *Protect Your Spine* aggressively enforces this and other agreements with entities to which we transmit transactions or from which we receive transactions, such as clearinghouses. *Protect Your Spine* will neither pursue nor knowingly retain a customer relationship with an entity that is either unwilling or unable to concur with reasonable privacy and confidentiality obligations.

Protect Your Spine recognizes that the transfer of medical data must be carried out in a manner that minimizes the risk of inappropriate disclosure and that safeguards the privacy and confidentiality of data that may identify individuals in their rules as patients and consumers. *Protect Your Spine* corporate policy is to observe all existing state and federal laws and regulations relating to the transmission, storage, and access of records and other health care data, and to maintain the security and confidentiality of patient-specific information.

The physicians of this office are contracted with many of the local and national managed care plans. However, there are some plans that we do not currently have contracts with. If you belong to a plan we are not contracted with our insurance / billing office will be glad to file a claim for you with the understanding that full payment is due at the time of service. Your claim will probably be applied to an out-of-network deductible or totally rejected. It is important for you to understand that the patient is ultimately responsible for the fees that are not covered by the provider in this case. If you have any questions concerning the coverage your plan has with *Protect Your Spine* please call the patient relations department of your provider.

Patient Consent for Use and Disclosure of Protected Health Information per the Health Insurance Portability and Accountability Act (HIPAA)

I **(Print Name)**_____, hereby certify that the personal medical information submitted is correct and that I seek medical treatment from *Protect Your Spine* and its staff. I hereby authorize such treatment as deemed appropriate and necessary by *Dr. Russell T. Elba* and the *Protect Your Spine* associates / staff.

X_____ Date: _____

(Signature of patient or parent / guardian of minor)

NOTICE OF PRIVACY PRACTICES: THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive in our facilities. This record is necessary to provide you with quality care and to comply with certain legal requirements. Chiropractors, physicians, consultants, specialists, and all others involved in your care may have different policies or notices regarding the use and disclosure of your medical information created and/or maintained at *Protect Your Spine*. Due to the nature of these services, we are required by law to maintain the privacy of certain confidential health care information, known as Protected Health Information (PHI), and to provide you with a notice of our legal duties and privacy practices with respect to your PHI. We are also required to abide by the terms of the version of this Notice currently in effect.

This notice will tell you about the ways in which we may use and disclose medical information about you, via any medium (written, oral, or electronic). We also describe your rights and certain obligations we have regarding the use and disclosure of medical information. We are required by law to: Make sure that medical information that identifies you is kept private. Give you this notice of our legal duties and privacy practices with respect to medical information about you. Maintain the privacy of certain confidential health care information, known as Protected Health Information (PHI).

USES AND DISCLOSURES OF PHI: We may use PHI for the purposes of treatment, payment and health care operations, in most cases without your written permission. Examples of our use of your PHI: **For Treatment:** This includes such things as obtaining verbal and written information about your medical condition and treatment from you as well as from others, such as chiropractors, doctors, nurses, and all others who give orders to allow us to provide treatment to you. We may give your PHI to other health care providers involved in your treatment, and may transfer your PHI telephone to the hospital or dispatch center. **For Payment:** This includes any activities we must undertake in order to get reimbursed for the services we provide to you, including such things as submitting bills to insurance companies, making medical necessity determinations and collecting outstanding accounts. **For Health Care Operations:** This includes quality assurance activities, licensing and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, as well as certain other management functions.

Use and Disclosure of PHI without Your Authorization. We are permitted to use PHI without your written authorization, or opportunity to object, in certain situations, and unless prohibited by a more stringent state law, including: For the treatment, payment or health care operations activities of another health care provider who treats you; For health care and legal compliance activities; To a family member, other relative, or close personal friend or other individual involved in your care if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection, and in certain other circumstances where we are unable to obtain your agreement and believe the disclosure is in your best interests; To a public health authority in certain situations as required by law (such as to report abuse, neglect or domestic violence; For health oversight activities including audits or government investigations, inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government (or their contractors) by law to oversee the healthcare system; For judicial and administrative proceedings as required by a court or administrative order, or in some cases in response to a subpoena or other legal process; For law enforcement activities in limited situations, such as when responding to a warrant; To avert a serious threat to the health and safety of a person or the public at large; For workers' compensation purposes, and in compliance with workers' compensation laws; Use or disclose health information about you in a way that does not personally identify you or reveal who you are. Any other use or disclosure of PHI, other than those listed above will only be made with your written authorization. You may revoke your authorization at any time, in writing, except to the extent that we have already used or disclosed medical information in reliance on that authorization.

NOTICE OF INDIVIDUAL RIGHTS: As a patient, you have a number of rights with respect to your PHI, including:

THE RIGHTS, COPY TO INSPECT YOUR PHI: This means you may inspect and copy most of the medical information about you that we maintain. We will normally provide you with access to this information within 30 days of your request. We may also charge you a reasonable fee, as state law permits, to provide a copy of any medical information you have the right to access. In limited circumstances, we may deny you access to your medical information, and you may appeal certain types of denials. We have forms available to request access to your PHI and we will provide a written response if we deny you access and let you know your appeal rights. You also have the right to receive confidential communications of your PHI. If you wish to inspect or obtain a copy of your medical information, you should contact our local privacy representative.

THE RIGHT TO AMMEND PHI: You have the right to ask us to amend written medical information we may have about you. We will generally amend your information within 60 days of your request and will notify you when we have amended the information. We are permitted by law to deny your request to amend your medical information only in certain circumstances, like when we believe the information you have asked us to amend is correct.

THE RIGHT TO REQUEST ACCOUNTING: You may request an accounting from us of certain disclosures of your medical information we have made in the six years prior to the date of your request. However, your requests for an accounting of disclosures cannot precede the implementation date of HIPAA April 14. 2003. We are not required to give you an accounting of information we have used or disclosed for purposes of treatment, payment or health care operations, or when we share our health Information with our business associates, such as our billing company or a medical facility from/to which we have transported you We are also not required to give you an accounting of our uses of PHI for which you have already given us written authorization. If you wish to request an accounting, contact our local privacy representative.

THE RIGHT TO REQUEST THAT WE RESTRICT THE USES AND DISCLOSURES OF YOUR PHI: You have the right to request that we restrict how we use and disclose your medical information we have about you. We are not required to agree to any restrictions you request, but any restrictions agreed to by us In writing are binding on us.

THE RIGHT TO OBTAIN A PAPER COPY OF THE NOTICE ON REQUEST: If you would like a paper copy of this Notice, you may contact us at the address listed below and we will provide you a paper copy of the Notice upon request.

REVISIONS TO THE NOTICE: We reserve the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to all PHI we maintain. Any material changes to the Notice will be promptly posted in our facilities and posted to our web site, if we maintain one you can get a copy of the latest version of this Notice by contacting our office.

YOUR LEGAL RIGHTS AND COMPLAINTS: You also have the right to complain to us, or to the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against in any way for filing a complaint with us or to the government. Should you have any questions, comments or complaints you may direct all inquiries to:

Dr. Russell T. Elba
Protect Your Spine ®
5810 Stirling Road, Hollywood, FL 33021

My signature below constitutes my acknowledgement of the Notice of Privacy Practices.

I **(Print Name)**_____, understand that *Protect Your Spine* may share my health information for treatment, billing and healthcare operations. I have been given a copy of the organization's notice of privacy practices that describes how my health information is used and shared. I understand *Protect Your Spine* has the right to change this notice at any time. I may obtain a current copy by contacting The Billing Office or the Facility.

X_____ Date: _____
(Signature of patient or parent / guardian of minor)

CONSENT FOR SERVICES: **The undersigned give consent to** *Protect Your Spine*, its authorized representatives, its chiropractors and associates, and/or Independent Contractors to provide appropriate medical services including diagnostic and radiologic procedures, and other treatment and care considered advisable or necessary by the patient's treating providers.

PERSONAL PROPERTY AND VALUABLES: I understand that *Protect Your Spine* is not responsible for any personal property or valuables lost or misplaced at our facility.

FINANCIAL OBLIGATION: In consideration of the services to be provided by *Protect Your Spine* and its physicians, providers, and Independent Physician Contractors, the undersigned jointly and severally, agree to pay all charges, deductibles, co-payments, and/or co-insurance amounts determined not paid or allowable by health insurance payers. Certain routine services and procedures, which are determined as necessary by the treating physician/provider, may not be covered by Medicare, Champus, Blue Cross and Blue Shield, and other third party payers. I/we agree to pay these non-covered services and/or procedures if ordered and performed by the treating physician/provider or *Protect Your Spine*. I agree to make payments according to *Protect Your Spine* credit terms. In the event I should default in payment of any of the above charges then I agree to pay all reasonable costs of collection, including a reasonable attorney's fee as might be allowed by law, whether the account shall be referred to a collection agency or an attorney.

ASSIGNMENT OF BENEFITS: The undersigned assign payment of authorized insurance benefits otherwise payable to the policyholder, including Medicare and Champus benefits, directly to *Protect Your Spine*, or it's authorized representatives who provide services. I certify that all information is correct which has been given to apply to payment under Medicare, Champus, managed care, and Blue Cross and Blue Shield, and other third party programs.

AUTHORIZATION FOR RELEASE OF INFORMATION: The undersigned authorize *Protect Your Spine* and its treating chiropractors / staff, to furnish any medical and billing information about this account, including but not limited to the following: INSURANCE BILLING – information requested by the insurance company, Medicare, Champus or other third party payers to support the claim submitted for payment of charges applicable to this account. MEDICAL NECESSITY AND APPROPRIATENESS OF SERVICES – Information requested by any utilization and/or Peer Review Organization associated with the insurer(s) to evaluate the medical necessity and appropriateness of services of the account or to determine the benefits for related services. This release allows disclosure about the treatment, diagnostic testing, or other medical information including psychiatric, alcohol, HIV, drug abuse, cancer registry treatment and follow-up and/or other confidential information. The recipients are prohibited from any re-disclosure of this information. The undersigned has the right to subsequently revoke this release. The revocation shall not pertain to information previously released. Information requested in good faith by any health care facility or physician for facilitating continuing care and treatment is authorized.

I ACKNOWLEDGE THAT I HAVE READ THIS FORM AND UNDERSTAND ITS PURPOSES AND CONSENT.

X_____ Date: _____
(Signature of patient or parent / guardian of minor)