Boonsboro Upper Cervical Chiropractic

28 N Main Street, Boonsboro, Maryland 21713
(240) 648-3030

NEW PATIENT APPLICATION FOR CARE

It is a pleasure to welcome you to our family practice. Please fill out this form as accurately as possible. Thank you.

Today's Date: _____

Name (First, MI, Last): _____ Date of Birth: _____

Address: _____

Contact: Phone [ ] cell [ ] home: _____ E-mail: _____

Preferred method of contact: [ ] Cell Phone [ ] Home Phone [ ] Voicemail [ ] Text [ ] Email

Occupation: _____ Military Veteran: [ ] Yes [ ] No

Marital Status: [ ] Married [ ] Single

Spouse: Name: _____ Date of Birth: _____ Mil Vet: [ ] Yes [ ] No

Children: Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name of Previous Doctor of Chiropractic: _____

Address: _____ Phone: _____

Reason for discontinuing care: _____

Name of General Practitioner: _____

Address: _____ Phone: _____

Health Insurance: Primary: _____ Secondary: _____

Do you know what Vertebral Subluxation is? If so, please briefly explain. _____

_____

How did you hear about our practice? _____

Who may we thank for referring you? _____

Patient Name: _____
DOB: _____

Patient Name: _____
DOB: _____

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (**Relief Care**). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (**Corrective Care**). It is the policy of this clinic to focus on **Corrective Care** for our patients.

Relief Care – that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak!

Corrective Care – differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time but is more lasting.

In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies:

Our clinic has established a single fee schedule that applies to all patients for each service provided.

You may be entitled to a network or contractual discount under the following circumstances:

- If you are covered by a State or Federal program with a mandated fee schedule.
- We are a network provider in a DMPO that you may join. Membership is $49.00 a year and covers you and your dependents. Ask our team for more information.
- If you are eligible & choose a pre-payment plan, auto-debit plan or "prompt payment" option.
- Military Veterans and their dependents.

Due to changes in health insurance fees, patient self-billing has become a much more cost-effective way for you, the patient, to get reimbursement for your care. Self-billing allows us to keep our fees low so you can get the care you need without any added cost. Therefore, we require all our patients to directly reimburse the clinic for services rendered. Statements will be provided for individuals to submit their own bills for reimbursement from third party payers upon request.

We do not want the financial investment in your health to be prohibitive of you receiving the care you need. We participate with CareCredit and can work with your budget for payment options.

The above information is true and accurate to the best of my knowledge. My reason for consultation with the Doctor is for evaluation of my physical health and the potential for improvement. I understand that the consultation is complimentary. Should I decide to progress with a complete Chiropractic Examination I understand those fees will have to be paid today, and that this practice operates on a zero-balance basis.

I authorize Boonsboro Upper Cervical Chiropractic to render necessary services to me and I understand that I am responsible for all charges incurred.

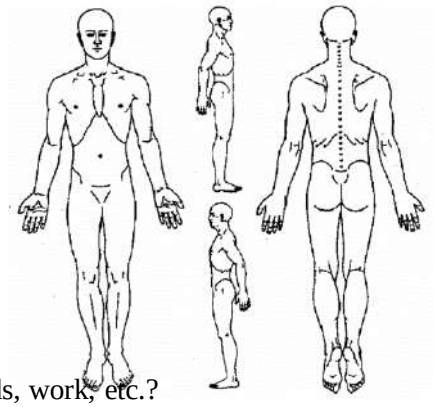
Patient/Parent/Guardian Signature: _____ Date: _____

Patient Name: _____
DOB: _____

What is the primary health concern that brought you in for care? _____

Is this new or old? _____ How long? _____

Please mark the areas of health concern on the diagrams to the right.---------->



How does this affect Activities of Daily Life? _____

_____

How does this prevent you from doing things you enjoy? (Sports, playing with kids, work, etc.?

_____

_____

Have you seen any other doctors for treatment? _____

Please list any secondary health concerns you may have.

_____

_____

_____

Surgeries/Hospitalizations/Traumas: -

_____

_____

_____

Family history (cancer, diabetes, cardiovascular disease, etc.):

_____

_____

List of current medications and/or supplements (medication/condition):

_____

_____

_____

What do you do to keep your spine healthy? _____

Patient Name: _____
DOB: _____

Do you use (please circle) tobacco/alcohol/drugs? ( ) Yes ( ) No

How often? _____ How long? _____

Check any of the following you have experienced in the last six months:

( )	Headaches	( )	Numbness / Tingling
( )	Sinus Congestion/Allergies	( )	Frequent Nausea / Vomiting
( )	Vision Problems	( )	Abdominal Cramps
( )	Earaches	( )	Constipation
( )	Dizziness	( )	Diarrhea
( )	Heart Problems	( )	Poor / Excessive Appetite
( )	Lung Problems / Congestion	( )	Excessive Thirst
( )	Blood Pressure Problems	( )	Painful / Excessive Urination
( )	Ankle Swelling	( )	Discolored Urine
( )	Prostate / Sexual Dysfunction	( )	Diabetes
( )	Cancer	( )	Menstrual Cycle Dysfunction

Females: Are you pregnant? ( ) Yes ( ) No ( ) Not sure

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CONSENT TO CHIROPRACTIC EXAMINATION AND CARE

I hereby authorize Boonsboro Upper Cervical Chiropractic and its licensed doctors and assistants, based on my complaints and the history I have provided, to undertake an examination and provide an evaluation and treatment plan which may include chiropractic adjustments and other tests and procedures considered therapeutically appropriate. I also wish to rely on the Practice doctors to make those decisions about my care, based on the facts then known, that they believe are in my best interest.

The nature and purpose of the chiropractic examination and evaluation, the chiropractic adjustments, and the other procedures recommended during my care have been explained and described to my satisfaction.

By signing below, I acknowledge my consent to be examined:

_____
Patient's Printed Name

_____ _____
Patient's Signature Date

The specifics of the doctor's recommendation will be further explained during a Report of Findings following your examination and any subsequent examinations and significant changes in your diagnosis or treatment plan.

Based on current findings, Practice doctors have discussed my diagnosis and treatment plan, the benefits and expected improvement with the proposed treatment and the reasonable alternatives to the proposed treatment. They have also explained the cost of my proposed care (or provided me with a current fee schedule) and to the extent practicable the costs of reasonable alternatives to the proposed treatment.

To aid the understanding of my condition and the reasons for the proposed course of care, the Practice has provided me with specific pamphlets and other literature (and videos) and Practice doctors have answered my questions regarding the planned treatments and course of care that I will receive. Practice doctors have also explained that my diagnosis and treatments may change during the course of care and that they will advise me of material changes in my diagnosis and treatment options and answer any additional questions that I may have at any time.

I have also been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should know of rare possible hazards and complications which may be encountered or result during the course of care. These include, but are not limited to, fractures, disk injuries, strokes, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctor.

I understand and accept that:

1. I have the right to withdraw from or discontinue treatment at any time and that the Practice doctors will advise me of any material risks in this regard.
2. That neither the practice of chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor during the course of my care.
3. That it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications or an undesirable result does not necessarily indicate an error in judgment or treatment.
4. The Practice does not guarantee as to results with respect any course of care or treatment.
5. My care and treatment will not be observed or recorded for any non-therapeutic purpose without my consent.

I have read this Consent (or have had it read to me) and have also had an opportunity to ask questions about the Consent and understand to my satisfaction the care and treatment I may receive. My signature below acknowledges my consent to the examination, evaluation and proposed course of care and treatments by the Practice.

_____

Patient's Printed Name

_____ _____

Patient's Signature Date

Doctor's Notes:
Patient counseled by:
Discussion: _____
Provision of chiropractic pamphlet: _____
Viewing video: _____

_____ _____

Signature of Doctor Date

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Notice of Privacy Practices

Patient Name: _____

Patient Signature: _____ **Date:** _____

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights
When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

You have the right to:
Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way about your medical information (for example, home or office phone) or to send your medical information to a different address.
- We will say, "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or healthcare item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared (disclosed) your health information, for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and healthcare operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
You can file a complaint with us if you feel we have violated your rights by contacting our Privacy Officer.

- To file a complaint with our organization, please submit your request in writing to the Privacy Officer Corinne Blanford, 28 N Main Street, Boonsboro, MD 21713, (240) 648-3030, info@boonsborouppercervicalchiropractic.com.
- You can file a complaint with the U.S. Department of Health and Human Services' Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, by calling 877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**
- We will not retaliate against you for filing a complaint.

Your Choices
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, contact us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference - for example, if you are unconscious, we may share your information if we believe it is in your best interest to do so. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these following cases, we **never** share your information unless you give us written permission:

- Marketing purposes
- Sale of your protected health information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again. We will honor your request to not contact you again.

Our Uses and Disclosures
We typically use or share your health information in the following ways:

- **Treatment**
  We can use your health information and share it with other professionals who are treating you.
  Example: A doctor treating you for an injury asks another doctor about your overall health condition.
- **Run our organization**
  We can use and share your health information to run our practice, improve your care, and contact you when necessary.
  Example: We use health information about you to manage your treatment and services.
- **Bill for your services**
  We can use and share your health information to bill and get payment from health plans or other entities.
  Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests
We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our **website, and we will mail a copy to you.**

Effective Date of Notice (To be Completed by Provider): _____

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Emergency Contact

Patient Name: _____ **Date:** _____

I hereby authorize Boonsboro Upper Cervical Chiropractic to contact the named individual(s) below in the event of an emergency.

Emergency Contact Information:

(1) Name: _____

Relationship: _____

Address: _____

City, State, Zip: _____

Home Telephone #: _____ Cell Phone #: _____

Work Telephone #: _____ Employer: _____

(2) Name: _____

Relationship: _____

Address: _____

City, State, Zip: _____

Home Telephone #: _____ Cell Phone #: _____

Work Telephone #: _____ Employer: _____

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Consent to Contact

How may we contact you? Dr. Blanford and Staff value your time and privacy, and we work hard to protect your personal information! We are working to optimize the way we communicate with you, so please let our Practice know the best way to reach you.

To improve the efficiency of scheduling appointments, providing Practice updates, and sending appointment reminders, we will be contacting you via email, text message, or leaving messages on answering machines and mobile telephones.

All our communications to you will be with the highest privacy possible. However, we want you to recognize that the privacy and security of email, text messaging, and telephone communication cannot be guaranteed.

By providing the information below you hereby authorize Boonsboro Upper Cervical Chiropractic staff to use your email address and/or telephone numbers for the sole purpose of corresponding with you to schedule appointments, provide you with Practice updates, and send appointment reminders.

We will not provide medical advice through email or telephone.

Please provide your contact information and indicate (Circle) if we may contact and/or leave messages:

Home Telephone: YES NO _____

Leave Messages: YES NO

Mobile Telephone: YES NO _____

Leave Messages: YES NO

Text Messages: YES NO

Work Telephone: YES NO _____

Leave Messages: YES NO

Email: YES NO _____

I understand I may revoke this consent, submitted in writing, at any time.

Patient Signature: _____ Date: _____

Patient Name Printed: _____

Staff Initials: _____