Healthcare Complete

260 Merrimac St.
Newburyport, MA 01950
978-499-9355

Confidential Patient Health Record

PERSONAL HISTORY- Nutrition Reactivation
UPDATE

Name: _____ **Date of Last Visit:** _____

**Only fill out this section if info has changed since last visit

Address: _____ Business Employer: _____

City: _____ Type of Work: _____

State: _____ Zip/Postal Code: _____ Cell Phone: _____

Home Phone Number: _____ E-Mail Address: _____

Date of Birth: _____ Age: __ Sex: □ M □ F Circle One: Single Married Widowed Divorced Separated

Name of Emergency Contact: _____ Name Of Spouse (If applicable): _____

Phone number of Emergency Contact: _____

CURRENT HEALTH CONDITION

Please list below the five main health concerns you have in order of their importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Medications You Take Now: _____
_____
_____

Supplements You Take Now: _____
_____
_____

Do You Suffer From Any Other Condition Other Than That Which You Are Now Consulting Us? _____
_____
_____

HEALTH HISTORY UPDATE

Please List and Describe any changes **SINCE YOUR LAST VISIT:**

Surgeries/New Scars : _____
_____

Traumas/Accidents: _____
_____

Illnesses/ Hospitalizations: _____
_____

Patient Signature: _____ Date: _____

OUR MISSION

To create optimal lifelong health and well-being for families, from newborns to seniors, by caring for the unique needs of the whole person and educating our community about the body's natural ability to heal.

This office is committed to providing patients with quality health care services delivered with dignity and concern. Fulfilling this commitment requires the efforts of the doctors, therapists, staff and patients working together as a team to obtain maximum results. Patient satisfaction is a vital interest to our staff.

Please direct any questions or concerns to a member of our staff. We encourage questions and/or concerns to avoid misunderstandings. Office hours allow our patients convenience to schedule appointments before and after work as well as during lunch. If you must miss an appointment, please notify us 24-48 hours in advance. **If you do not notify us prior to 24 hours to cancel an appointment or do not show up for your scheduled appointment, you will be charged $25.00 as a missed appointment fee that you must pay before you are seen or treated again**.
This facility shall not be liable for lost, damaged or stolen property and patients are encouraged to leave valuables at home. Cell phones should be silenced to accommodate for the healing environment. We are a fragrance-free facility and ask that you refrain from wearing fragrances.

HEALTHCARE PRIVACY NOTICE/HIPPA

We are very concerned with protecting your personal health information. There may be times our office may need to contact you regarding office matters. By signing below, you have authorized this office to contact you for office related matters and thank you notices for referrals using your first name in the following manner: phone-work-home or mobile, text messages, e-mail and regular mail to include sealed envelopes and postcards. Messages may be left on an answering device/voicemail, or with the person answering your phone-home-work-mobile. Also, in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated September 23, 2013, this office is obliging to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient.

I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY OF: *NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION/HIPPA*

____(Initial) **Optional authorization:** I authorize that this office may share my health information, appointment, and financial arrangements with the people listed here: (List person(s)) _____

AUTHORIZATION TO PERFORM EXAMINATION

The process of determining suitability for Chiropractic Services involves answering fully and truthfully all questions presented to you either written or spoken regarding your past and present health status. If warranted, a physical examination will be performed that can include but is not limited to vitals measurement, systems evaluation, orthopedic tests, and maneuvers (tests that move and stress parts of the body), neurological test (tests using sharp or dull instruments, smells, or sounds, gently tapping) as well as physical touching. These tests and maneuvers will help the Chiropractor determine what may be causing your complaints. Occasionally, some temporary soreness and/or stiffness may occur due to the examination. Less frequently an aggravation of presenting symptoms or initiation of new symptoms may occur. By signing below, you have authorized the performance of a consultation and examination.

ASSIGNMENT OF BENEFITS/AUTHORIZATION & LIEN

I, the assignee, being the patient or the legal guardian for said minor listed below, do hereby irrevocably authorize, direct, assign and give a full lien to the office named above and listed below, hereinafter referred to as the "Facility" against any & all insurance benefits, proceeds of any settlement, judgment or verdict which may be paid to the undersigned as a result of the injuries or illness for which I have been treated by the Facility.

I, the assignee, further authorizes any and all insurance company(s), attorney, and any third party payer to pay the Facility all sums of money due them for any & all services rendered to me or minor by whom I am responsible for by reason of accident, illness and by any & all reason of any other bills that are due or may become due, and to withhold such sums from any health & accident, workers compensation and or third party benefits.

Assignee agrees that this facility & staff may deliver medical records, consultations, depositions, and/or court appearances which must be paid in full in advance and authorizes this Facility to release any information pertinent to said health care to any insurance company, adjuster, attorney, or legal service bureau to facilitate collections under the terms of this document. Assignee grants this Facility a full power of attorney to endorse any checks for payments to this office for any indebtedness owed to this office for services rendered to the patient.

INSURANCE BENEFITS/CREDIT POLICIES/DISCOUNTS/PAYMENT TERMS/REFUND TERMS

As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us, but some third-party payers misquote benefits, coverage, and liability. Our Facility & staff are not responsible for what a third-party payer and/or a representative may tell us. Any contractual, written, verbal, or other obligations or arrangements between you and an attorney, insurance company, liable or third-party payer are between you and said person. Our Facility will file initial insurance claims for you.

Co-pays, deductibles, and all non-covered service charges are due the day the service is rendered. For your convenience we accept cash, check, debit and credit cards which are kept in encrypted files. For patients who have insurance plans for which we are out-of-network, you are responsible for charges on all service(s) and/or product(s) which insurance reimbursement is lower than our billed amount.

All account balances, including automobile and or work injury claims must be paid in full within 90 days of the release of treatment. Patients are fully responsible for all money owed this office and such payment is not contingent on any settlement, claim, judgment, or verdict by which they may eventually recover the said fee and it is also regardless of any attorney liens or pending settlement(s). If a third party payer fails to pay said balance in full within the 90 day period, the patient must pay the balance in full. Assignee is fully responsible for all money owed this Facility for any and all treatment, products, and services rendered to the patient or minor shown below. This office requires a credit card to be kept in our secure files. If charges are over 90 days past due or in the unlikely event insurance does not cover services rendered, Healthcare Complete will contact the assignee to utilize the credit card on file to pay for balances owed.

A service charge is computed by a "periodic rate" of 1.5 % per month-18% per annum & is added to all balances owed 60+ days. Any balance past due 90 days or more may be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly service charges, interest, costs related to but not limited to all collections related expenses, attorney fees, court & filing fee's. Returned checks, debits & credit charges made payable to this Facility for insufficient funds, stop payments, or other of non-payment will be assessed a $30.00 charge.

If a patient decides to terminate a pre-paid care plan prior to the termination date or visit limit, the patient shall be entitled to a refund. The refund shall equal the lump-sum amount(s) paid less any and all sums due for the services actually performed, including adjustments or other treatments, and examinations, re-examinations and consultations. Refund requests must be made in writing to the office and funds will be paid to the patient within 30 days of the termination by either party.

Your signature on this document confirms that you have read, understand and agree to comply with all of the terms & conditions of the Health Care Privacy Notice and all policies, consents, terms & conditions regarding your responsibilities to this Facility and that you grant the physicians, therapists and/or staff of this Facility to use and share your confidential health information with others in order to treat you and/or to arrange for payment of your bill and/or for issues that concern this Facility operations and responsibilities.

Patient Signature: _____ Printed Name: _____Date: _____
Doctor Signature: _____Printed Name: _____ Date: _____