Groves Family Chiropractic

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to that information. Please review this notice carefully, and sign to acknowledge receipt of this information.

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when the files are taken to and from the Practice by placing the files in a box or brief case and kept within the custody of a doctor or employee of the Practice authorized to remove the files from the Practice's office. It may be necessary to take patient files to a facility where a patient is confined or to a patient's home where the patient is to be examined or treated. If you have further questions, please contact the compliance officer, Matt Groves, D.C.

No Consent Required

The Practice may use and/or disclose your PHI for the purposes of:

1. Treatment – In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you for a condition or disease may need to know the results of your latest physician examination by this office.
2. Payment – In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice can be properly reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.
3. Health Care Operations – In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

The Practice may use and/or disclose your PHI, without a written Consent from you, in the following additional instances:

1. De-identified Information – Information that does not identify you and, even without your name, cannot be used to identify you.
2. Business Associate – To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as an associate doctor, billing company or massage therapist that assists the office in submitting claims for payment to insurance companies or other payers.
3. Personal Representative -To a person who, under applicable law, has the authority to represent you in making decisions related to your health care
4. Emergency Situations:

   (i) for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or
   (ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

5. Communication Barriers – If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.

6. Public Health Activities – Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.
7. Abuse, Neglect or Domestic Violence – To a government authority if the Practice is required by law to make such disclosure; if the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm
8. Health Oversight Activities – Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.
9. Judicial and Administrative Proceeding – For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.
10. Law Enforcement Purposes – In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.
11. Coroner or Medical Examiner – The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.
12. Organ, Eye or Tissue Donation – If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.
13. Research – If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI and that does not identify you and, even without your name, cannot be used to identify you.
14. Avert a Threat to Health or Safety – The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.
15. Workers' Compensation – If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

_____ _____ _____

Printed Name of Patient | Signature of Patient or Representative | Date

_____

Relationship to Patient

If you would like to give us permission to share your protected health information with anyone else, you may list their names below: (Optional)

_____

_____

I authorize Groves Family Chiropractic to disclose my protected health information to the individuals listed above.

_____ _____ _____

Printed Name of Patient | Signature of Patient or Representative | Date

_____

Relationship to Patient

Groves Family Chiropractic

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

Primary Insurance Company_____

Secondary Insurance Company_____

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Groves Family Chiropractic medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinics expenses.

I further authorize Dr. Matthew Groves of Groves Family Chiropractic and his staff to perform such services deemed necessary to treat my condition(s). I understand that I am fully responsible for all charges that may include legal fees, collection fees, or other expenses incurred by the provider in collecting my account.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____ _____

Printed Name of Patient | Signature of Patient or Representative | Date

_____

Relationship to Patient

Groves Family Chiropractic

CONSENT TO CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic or physical therapy/physiotherapy procedures on me or on _____ by Matthew Groves, D.C., and/or other licensed doctors of chiropractic who may be employed by or engaged in practice at Groves Family Chiropractic.

I have had an opportunity to discuss with Matthew Groves, D.C. or other clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that the practice of neither 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 at the time; that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable result does not necessarily indicate an error in judgment; that no guarantee as to results has been made to nor relied upon by me, and I wish to rely on the doctor to exercise judgment during the course of the procedure which he/she feels at the time, based upon the facts then known, is in my best interests. I also understand that failure to follow prescribed care plans or referrals may result in adverse outcomes. I understand that chiropractic care may not be the only type of care available for my condition, and it may not completely cure my condition. I recognize and accept that there may be some residual symptoms following a course of care.

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 possible complications which have been alleged. 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 have read or have had read to me the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, acknowledge my understanding of its contents.

_____ _____ _____

Printed Name of Patient Signature of Patient or Representative Date

_____

Relationship to Patient

____ Please initial here if the patient is a minor, and you authorize examination, management, and treatment without a parent or guardian present.

Groves Family Chiropractic

FINANCIAL POLICY AND OFFICE FEE SCHEDULE
(If you have no insurance or limited insurance coverage, make sure to ask us about joining CHUSA)

Service	Actual Fee	CHUSA Member Discount Fee (Save 30% or more)
Initial Consultation	Free	Free
Examination	$45-$110	$30-$75 (First visit no more than $200 total)
X-Rays (Per Region)	$72-$93	$50-65
Physical Therapy	$25	$3-$20
Spinal Adjustment	$40-$55	$30-$40 ($20 for routine children visits)
Extremity Adjustment	$15	$10
CHUSA Yearly Fee		$49
These fees may be subject to change		

Groves Family Chiropractic is committed to providing you with the best chiropractic care possible in a caring environment and has established these financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time service is rendered unless specific arrangements are made in advance.

Missed Appointments Groves Family Chiropractic reserves the right to charge for appointments missed or cancelled without notice. It is your responsibility to alert Groves Family Chiropractic by phone if you are unable to make your appointment.

Health Insurance If you have insurance that covers chiropractic, Groves Family Chiropractic will verify your chiropractic benefits. This will help you to understand how much your responsibility will be. You will be responsible for any fees not covered by your insurance company. Discounts are available through the ChiroHealthUSA program. For more information about this, ask one of our staff. Medicare does not cover exams, x-rays, or physical therapy done by a chiropractor.

Delinquent Balances There is a .75% per month finance charge on overdue balances. In the event your account is past due, it may be turned over to a collection agency. In the event the account is not paid in full, and this account is turned over to a collection agency and/or attorney, then you agree to be responsible for finance charges of .75% per month from the date of invoice, all reasonable fees necessary for the collection of the account including, but not limited to, collection agency fees of 50% of the balance due and costs and reasonable attorney fees of 33% of the balance due.

Returned Checks There is a $25.00 fee for all returned checks.

Personal Injury/Worker's Compensation If you are in an auto or work accident, and you require claims to be submitted to a different insurance company, you must inform us immediately so that a new exam can be completed, and proper insurance billing procedures may be performed. In this case, all insurance reimbursements will go directly to Groves Family Chiropractic.

X-rays X-rays performed in this office will be read by a third-party radiologist. The fee for this service will be billed separately. The name of this company is Great Lakes Imaging Consultants, P.C.

By signing below, you acknowledge these terms and agree to them.

_____ _____ _____
Printed Name of Patient Signature of Patient or Representative Date

_____
Relationship to Patient

Groves Family Chiropractic

CONFIDENTIAL PATIENT CASE HISTORY

Date_____

Legal Name_____ Date of Birth_____

Address_____ City_____ State_____ Zip_____

Cell Phone_____ Work Phone_____ E-mail Address_____

Age_____ Sex_____ Marital Status_____ Spouse's Name_____

Occupation_____ Employer_____

How did you hear about Groves Family Chiropractic?_____

Primary complaint today_____

Is your condition due to an accident? □ Yes □ No Date of Accident_____

To whom have you made a report of your accident? □ Auto Insurance □ Employer □ Work Comp.

□ Other Attorney's Name (if applicable) _____

What date did your symptoms appear?_____

Did your symptoms appear gradually or suddenly? □ Gradually □ Suddenly

What caused or contributed to the onset?_____

Have you ever had anything like this before? □ Yes □ No

was the outcome?_____

Type of pain □ Dull □ Sharp □ Burning □ Aching □ Gnawing □ Throbbing □ Shooting
□ Constricting □ Numbness □ Tingling □ Stiff □ Nagging □ Other_____

Rate the severity of your pain right now 0 1 2 3 4 5 6 7 8 9 10

No Pain Worst Pain

Is the pain constant or does it come and go? □ Constant (Present 75% of the day or more)

□ Episodic (Tied to a particular event or time of day)

□ Intermittent (Often unpredictable)

Is this condition progressively getting better or worse? □ Better □ Worse □ Same

Have you found anything that makes it better? (Morning, Evening, Rest, Certain Positions) □ Yes □ No

Explain_____

Have you found anything that makes it worse? (Positions, Activities, Coughing, Sneezing, Straining) □ Yes □ No

Explain_____

Has there been a change in any bodily functions? (Urination, Respiration, Digestion, Vision, Sexual) □ Yes □ No

Explain_____

How has your complaint affected your daily activities?

	No Affect	Mild Affect	Mod. Affect	Severe Affect		No Affect	Mild Affect	Mod. Affect	Severe Affect
Sitting	□	□	□	□	Grocery shopping	□	□	□	□
Rising from chair	□	□	□	□	Household chores	□	□	□	□
Standing	□	□	□	□	Lifting objects	□	□	□	□
Walking	□	□	□	□	Reaching overhead	□	□	□	□
Lying down	□	□	□	□	Showering or bathing	□	□	□	□
Bending over	□	□	□	□	Dressing myself	□	□	□	□
Turning over in bed	□	□	□	□	Reading	□	□	□	□
Using a computer	□	□	□	□	Getting to sleep	□	□	□	□
Getting in/out of car	□	□	□	□	Staying asleep	□	□	□	□
Driving a car	□	□	□	□	Concentrating	□	□	□	□
Caring for family	□	□	□	□	Exercising	□	□	□	□
Looking over shoulder	□	□	□	□	Yard work	□	□	□	□

Have you tried any store bought, prescription, or home remedies? □ Yes □ No

If so, how effective have they been?_____

Have you sought other professional care for this condition? (Surgery, Physical Therapy, Injections) □ Yes □ No

Explain_____

Where did you receive this treatment?_____

Have you had previous chiropractic care? □ Yes □ No When?_____

Name of Chiropractor_____ City_____

Who is your primary medical doctor?_____ Facility_____

Are there any other back or neck complaints that you would like us to address? □ Yes □ No

Describe_____

Date it began_____ Cause_____ Severity_____

Activities that make better _____ Worse_____

Date of last Physical Exam_____ Spinal X-Ray_____ Blood Test_____

Spinal Exam_____ Chest X-Ray_____ Urine Test_____

Dental X-Ray_____ MRI_____ CT_____

List any surgical procedures and dates of each_____

_____

_____

List any automobile accidents with dates and any injuries sustained_____

_____

_____

List any falls, head injuries, broken bones, or dislocations and dates of each_____

_____

_____

List any drugs, vitamins, and herbal supplements you are now taking_____

_____

_____

Indicate if you or any relatives have the following conditions. S=Self P=Parent GP=Grandparent Sib=Sibling

Skin

Skin Lesions_____

Psoriasis_____

Cancer_____ Type_____

Other_____

Neurological

Numbness_____

Weakness_____

Epilepsy_____

Seizures_____

Cancer_____ Type_____

Genitourinary

Kidney Stone_____

Kidney Problems_____

Infection_____

Loss of bowel or bladder control_____

Cancer_____ Type_____

Cardiovascular

Heart Disease_____

Heart Failure_____

High Cholesterol_____

High Blood Pressure_____

Low Blood Pressure_____

Gastrointestinal

Acid Reflux_____

Stomach Problems_____

Digestive Problems_____

Liver Problems_____

Gall Stones_____

Cancer_____ Type_____

Constitutional/Misc.

Anxiety_____

Depression_____

Nausea_____

Dizziness_____

Diabetes_____

Obesity_____

Ear Infections_____

Autoimmune Disease_____

Lupus_____

Thyroid Problems_____

Eating Disorder_____

Sleep Apnea_____

Other cancer_____ Type_____

Respiratory

COPD_____

Emphysema_____

Persistent Cough_____

Asthma_____

Lung Cancer_____

Musculoskeletal

Neck Pain_____

Mid Back Pain_____

Lower Back Pain_____

Leg Pain_____

Arm Pain_____

Disc Herniation_____

Migraine_____

Headaches_____

Scoliosis_____

Osteopenia_____

Osteoporosis_____

Ankylosing Spondylitis_____

Osteoarthritis_____

Rheumatoid Arthritis_____

Bone Cancer/Metastasis_____

If there are any additional health issues that you currently have, please list them here_____

_____

_____

Exercise Habits	□ None	□ Moderate	□ Daily	□ Heavy
Work Activity	□ Standing	□ Sitting	□ Light Labor	□ Heavy Labor
Do you currently smoke cigarettes?	□ Yes □ No	Packs/Day_____		
Have you ever been a smoker?	□ Yes □ No			
Do you consume alcohol?	□ Yes □ No	Drinks/Week_____		
Do you consume caffeine?	□ Yes □ No	Cups/Day_____		
Are you under excessive stress?	□ Yes □ No	Reason_____		
Are you pregnant?	□ Yes □ No	Due Date_____		
Do you have any allergies	□ Yes □ No	Describe_____		