Abby Chiropractic

New Patient Registration

Patient Information

_______________________________ (First, Middle, Last Name)

_______________ (Date of Birth)

XXX - XX - ________ (Last 4 digits of S S N)

_______________________________ (Address)

_______________________________ (City, State, Zip Code)

_______________ (Home Telephone Number)

_______________ (Work Telephone Number)

_______________ (Cell Phone Number)

_______________________________ (Email Address- will not be released to anyone outside the clinic)

_______________________________ (Cell Phone Carrier- AT&T, Verizon, etc - For Text Appointment Reminders)

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Sex: ☐Male ☐Female ☐ Other

Employment Status: ☐Employed ☐ Part-time Student ☐ Full-time Student ☐ Other

Emergency Contact Information

_______________________________ (Name – First & Last) (Relationship

_______________ (Phone Number)

_______________________________ (Primary Care Physician)

_______________ (Phone Number)

Employment Information

_______________ (Occupation)

_______________________________ (Employer)

_______________________________ (Address)

_______________ (City, State, Zip)

How were you referred to our office?

Whom may we thank for referring you to us? _______________________________

No Call / No Show Fees

Patients who fail to show up for an appointment without calling are subject to a $40 fee.
Patients with scheduled MASSAGE or ACUPUNCTURE appointments
must call a minimum of FOUR (4) HOURS prior (during business hours) to cancel or reschedule.

Attention Patients

We have therapy animals in our office.
Please notify the front office staff if you have an allergy or want the animals put away.

_______________________________ Patient (or Guardian) Signature

_______________ Date

Assignment of Benefits Notice

This office will provide insurance billing services for you if you so desire as a courtesy. Remember that you are ultimately responsible for any charges incurred in this office. It is your responsibility to pay any deductible amount, co-insurance, and or any other balances not paid by your insurance carrier, including services deemed not medically necessary. Your signature on this document indicates that you agree to pay for any outstanding bills incurred in this office.

In order to keep our office overhead down and keep our patient fees reasonable, we ask for payment at the conclusion of each treatment for cash patients and the deductible and/or co-payment for regular insurance patients. If insurance benefits are not verified at the time of service, it is office policy that you pay the first visit in full. Should insurance benefits subsequently pay, a refund check or account credit will be issued.

Unless other prior written agreements have been made, any outstanding account balance more than 45 days old is considered delinquent. Office policy requires those accounts to be assigned to a collection agency, with the potential to be referred to the local attorney or small claims court, and your credit report may be blemished. Should this occur, an administrative collection fee will be applied at a **minimum** of 30% of the total account balance to cover our costs and you specifically authorize us and any agency of assignment to run your credit report. In addition, an interest charge of 1.5% will also be added to accounts that are delinquent. The 1.5% interest will be applied once per month from the first date of delinquency to the date of assignment to collections.

Please be advised that we will bill the insurance company whose information you provide to us for the services you receive. However, if after 45 days of billing for services, that insurance carrier denies coverage or has not paid for your care for any reason, we will not provide any further insurance billing. Your care and payment of services will be fully your responsibility. As a courtesy, you will have the option to pay off your entire balance at our time of service discount (our lowest fee schedule) for any outstanding charges, if you do so within 15 days of notice. After that time, our full fees apply.

I authorize payment of insurance benefits directly to Dr. Corll or Complete Care Chiropractic. I authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers, collection agencies, and payers to secure the payment of benefits. I further authorize Dr. Corll to contact my primary physician as needed to advise of my concurrent treatment.

My signature below indicates that I have read and understand and agree with the terms on this page titled Assignment of Benefits Notice.

______________________________ ______________

Patient (or Guardian) Signature Date

Financial Policy

As noted earlier, you the patient are ultimately responsible for all charges resulting from care at our clinic. This is true regardless of any agreement you have with your insurance company.

Insurance Patients

Patients with a Co-pay: There will be a fixed amount ($10, $15, $25 etc.) or a percentage of fees for the services provided on each visit, depending on your policy.

Patients with a deductible have two options:

1) You can pay our regular fee schedule and we will bill insurance for you. This notifies the insurance company that your deducible should be reduced by what you pay on each visit. If and when the deductible is met, your plan will most likely switch to a co-pay status.
2) You can pay our Time of Service fees, which are significantly less than our regular fees, but YOU will be responsible for submitting all services you have paid for to your insurance for reimbursement. We will not be billing on your behalf

Non-Insured Patients

Since we are not paying staff to bill and follow up with insurance companies, we pass the savings onto you. We offer EVERYONE our *Time of Service* rates when their accounts are paid in full on each visit.

Our fee schedules are adopted from State and Federal Laws.

Our regular fees are set by the Oregon Legislature on a yearly basis in accordance with the Workman's Compensation Fee Schedule.

Our Time of Service fees are determined by the Federal government on a yearly basis with the Medicare Fee Schedule.

A written copy of our fee schedule is available upon request.

____________________________________ ________________

Patient (or Guardian) Signature Date

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. HIPAA stands for Health Information Privacy Accountability Act.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_______________________________________ ____________________

Patient (or Guardian) Signature Date

Implied Consent

Dear Patient:
It is prudent for us to obtain your informed consent prior to examination and treatment. The purpose of this information is to inform you, not to alarm you. What you are being asked to sign is simply a confirmation that we have discussed the following:

Associates and Assistants
In this office we use trained staff personnel to assist the doctor with portions of your consultation, examination, and treatment. Occasionally when your doctor is unavailable, another clinic doctor will treat you.

Treatment
The Chiropractic Adjustment: I will use my hands or an instrument upon your body in such a way as to move your joints. This procedure may cause an audible "pop" or "click" much as you have experienced when you "crack" your knuckles. There are some material risks involved in doing this and they are as follows:

Inherent Risks
Pain: It is possible for an adjustment as well as traction, massage therapy, exercise, in fact almost any treatment, to result in temporary increase in soreness in the region being treated. It is not common but it does happen sometimes. Doing any form of care on an inflamed painful region has the potential to irritate it as the healing process begins.

Soft Tissue Injury: Soft tissue, such as ligaments and muscle may be stretched or torn during an adjustment. The result is a temporary increase in pain. However, there are no long term effects. These problems occur so rarely I have not been able to find available statistics to quantify their probability.

Rib Fractures: The force of an adjustment might "crack" a rib. This can happen with anyone, however, it occurs most often in patients that have weakened bones from such things as osteoporosis. These problems occur so rarely that I have not been able to find available statistics to quantify their probability.

Disc Herniations: Occasionally treatment will aggravate or cause a problem if the disc is in a weakened state. It is possible that surgery may become necessary for correction, but again these problems occur so rarely that I have not been able to find available statistics to quantify their probability.

Stroke: Even though strokes happen with some frequency in our world, strokes resulting from chiropractic adjustments are very rare. There is no reliable practical test or exam that can detect the possibility of a stroke secondary to chiropractic care. The incident of stroke in relationship to chiropractic care is so rare that you have the same chance of getting hit by lightning; one in a million.

Physical Therapy Burns: We use electronic digitally controlled heat pads. Although there are inherent variations in actual temperature, the chance of being burned are extremely small, but is possible.

Other Problems: There may be other problems or complications that might arise from treatment, such as massage, traction, etc., than noted above. These other problems or complications occur so rarely that it is not plausible to anticipate and/or explain them all in advance of treatment.

Other Treatment Options (non-chiropractic):
Medication: Medication may be used to relieve pain and swelling. However, medication can mask progress and the efficiency of chiropractic treatment. Caution should be used since the danger of side effects and damage to the health of the person taking the medication is well documented.

Hospitalization: Hospitalization has proven expensive and dangerous. The documentation of such is overwhelming.

Surgery: Risks associated with surgery are well known. Anesthesia complications, post-surgical pain and scarring, and the required used of potent medications make surgery an option only after conservative methods have failed.

Non Treatment:
Remaining untreated can result in tissue adhesions, pain, and reduction in associated joint mobility. These complications can and often interfere with the quality of life.

****Acupuncture Treatment**
Methods of treatment used in this practice may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, herbal therapy, massage, Qi Gong, and nutritional counseling. I understand that acupuncture, moxibustion, electrical stimulation, cupping and pricking are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Unusual risks of acupuncture include dizziness, fainting or nerve damage. Infection is possible, although the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment. Potential risks of moxibustion health therapy are burns, blistering, or scarring. Temporary bruising or redness lasting a few days is a common side effect of cupping and gua sha, or spooning. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

I understand that herbal and nutritional supplements recommended to me by my acupuncturist are safe in the recommended doses. Large doses of herbs taken without my practitione's recommendation may be toxic, and some herbs are inappropriate during pregnancy. Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand thatI must stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse reactions. I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose.

Consent to Treatment

I HEREBY STATE THAT I HAVE READ OR HAVE HAD READ TO ME THIS CONSENT FORM PRIOR TO MY SIGNATURE BELOW AND CONSENT TO CARE BY DR. CORLL AND HIS STAFF.

Date: ___________________________

Patient (or Guardian) Signature: ____

Patients Printed Name: ____