Greenville Rehab & Pain Clinic

Date: _____

Patient Information

Name: _____
Last First MI

Email address: _____

Mailing Address: _____
Street Address City State Zip

Phone # (H)_____ (W) _____ (Cell) _____

Cell phone carrier _____

Can we call you at work? ❑ Yes ❑ No Can we text you for Appointment reminders & leave you voice mails? ❑ Yes ❑ No

Date of Birth: _____ Sex: ❑ Male ❑ Female SS#: _____

Please describe the condition you are experiencing_____

_____

Occupation: _____ Employer: _____

How did you hear about our practice? _____

Emergency contact: Name: _____ Relation: _____ Phone #: _____

Accident Information

Is this visit due to an accident? ❑ Yes ❑ No If yes, what type? ❑ Auto ❑ Work ❑ Other _____

Has it been reported? ❑ Yes ❑ No If yes, to whom? _____

Assignment and Release (insured patients)

- I authorize the release of any medical or incidental necessary for treatment, payment or health care operations or to process my insurance claims; A copy of this authorization can be used in place of the original.
- I AUTHORIZE, REQUEST AND ASSIGN MEDICARE AND/OR MY INSURANCE COMPANY AND TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE BENEFITS.
  I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions. Prior to receiving chiropractic care this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care. I understand and accept that there are risks associated with chiropractic care and give consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.
- I HEREBY GIVE MY CONSENT TO GREENVILLE REHAB AND PAIN CLINIC DOCTORS AND THEIR STAFF TO EXAMINE AND TREAT MY CONDITION.

SIGNATURE (X) _____ **DATE** _____

Greenville
Rehab & Pain Clinic
A TEAM APPROACH TO YOUR HEALTH

Dr. Matt Chenault, DC
Dr. Larry Bruno, DC

HIPAA Notice of Privacy Practices

Summary HIPAA Notice of Privacy Practices

Greenville Rehab and Pain Clinic comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Greenville Rehab and Pain Clinic protect confidential health care information, known as "Protected Health Information" (PHI). Below is a summary of your privacy rights under HIPAA. Greenville Rehab and Pain Clinic's legal duties and privacy practices regarding your PHI are also included in this Summary Notice.

Summary of Your Privacy Rights

Greenville Rehab and Pain Clinic may use and give your health information to:

- Treat you
- Get paid
- Operate health care services

Greenville Rehab and Pain Clinic may use and give your health information, with no consent required, for:

- Law enforcement requests
- Judicial and administrative proceedings related to legal actions
- Healthcare fraud and abuse detection or compliance with the law
- Use by another healthcare provider treating you
- Government health oversight activities
- Reports required by law related to births, deaths or diseases
- Reports required by law related to neglect and abuse, or domestic violence
- Notifying a party about exposure to a possible communicable disease
- Use by another healthcare provider for payment to that provider
- Military, national defense and security or other governmental functions
- Workers' compensation purposes and in compliance with related laws
- Averting a serious threat to public health and safety
- Risk adjustment activities under the Affordable (AIC) Act. The practice may disclose your PHI to an insurance company, health plan or their designated business associates. In response to the insurance company's or health plan's request for medical records to address and report risk scores to the Department of Health and Human services.

You have the right to:

- Inspect or get a copy of your medical record
- Change information on your medical record if you think it is incorrect
- Get a list of persons whom Greenville Rehab and Pain Clinic shared your PHI
- Ask Greenville Rehab and Pain Clinic to limit the information it shares
- Ask for a copy of your privacy notice
- Write a letter of complaint to Greenville Rehab and Pain Clinic or the federal government

If you have any questions or if you wish to file a complaint, exercise any rights listed in this Summary or the complete Notice, please contact the Privacy Officer at Greenville Rehab and Pain Clinic.

I acknowledge that I have read and understand the HIPPA Privacy Practice.

Patient Name (Printed) _____Date_____

Patient Name (Signed) _____Date_____

OFFICE FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care.

1. **If you do not have insurance:** All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $100 at any time or care may be terminated. Our payment plans make care an affordable part of your family budget.

2. **If you have insurance:** All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed $100 or care may be terminated. Our payment plans make care an affordable part of your family budget.

You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage. We do accept assignment for secondary insurance carriers and will be happy to forward all necessary paperwork.

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard and of care in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

When your schedule of visits is once per month or longer, you will not be eligible for insurance assignment. Charges for services rendered will be due as they are rendered. We will continue to provide you with an insurance claim form.

If you discontinue to care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

You understand and agree that regardless of your insurance status you are ultimately responsible for the balance on your account for chiropractic services rendered. If we must take additional steps to collect this amount, you will pay all costs of collection. Collection costs include court costs, reasonable attorney's fees and collection agency commissions or charges. A collection agency commission is typically 33 1/3 to 50% of the unpaid balance. You also agree to release any information in order for the collection agency to reach you . You also request payment of government benefits either to our office or to the party who accepts assignment below. This authorization will remain in effect until revoked by you in writing.

All checks returned for non-payment will be assessed an additional $25.00 fee.

Patient's Printed Name:_____

Signature: _____ Date:_____

Finance Counselor:_____ Date:_____

Greenville Rehab & Pain Clinic (GRPC)
CONSENT TO CHIROPRACTIC EXAMINATION AND CARE

I hereby authorize _____ (GRPC) 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 understand that Illinois law entitles me to receive information concerning my condition and proposed treatment, and to refuse any treatment to the extent permitted by law. With that knowledge and with my consent, I 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 that may be recommended during the course of my care have been explained and described to my satisfaction.
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.

[IF APPLICABLE] 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 that relate to physical aberrations unknown or reasonably undetectable by the doctor.

This document is intended as a general, broad-based consent applicable to any and all contemplated procedures. However, without in any way limiting the general applicability of this Consent, in the event the Practice has recommended that I undergo cervical (neck) adjustment or manipulation based on my diagnosis and condition, the Practice has also informed me specifically regarding cervical (neck) adjustment and manipulation as follows: There is a rare association of this type of adjustment or manipulation with stroke due to compromise of the veretebrobasilar (VBA) artery (a neck artery at the base of the brain). In 2008, the risk was reported to be 1 case per 400,000 to 1,000,000 cervical spine adjustments in a study of VBA stroke patients admitted to Ontario hospitals from 1993 – 2002. [1] To the best of my knowledge, this is the largest research study to date on this issue. The study found positive association between *both* primary care (medical) visits and chiropractic visits with VBA stroke in this patient population. The study also found that practitioner visits billed for headache and neck complaints were highly associated with subsequent VBA stroke.

The study concluded that VBA stroke is a very rare event in the population, and that the increased risks of VBA stroke associated with chiropractic visits and primary care (medical) visits is likely due to patients with headache and neck pain from VBA dissection seeking care before their stroke. **The study found no evidence of excess risk of VBA stroke associated with chiropractic care compared to primary care.**

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[1] Cassidy JD, Boyle E, Cote P, *et al.* Risk of vertebrobasilar stroke and chiropractic care: results of a population-based case-control and case-crossover study. *Spine*, Feb 15 2008;33(4 Suppl):S176-183. Republished in *J Manipulative Physio. Ther,* 2009 Feb;32(2Suppl):S201-8.

Some organizations, media outlets and Internet sites have publicized statements asserting an anecdotal association between neck manipulation or adjustment and VBA stroke. However, the Practice believes that the Ontario study cited above is the largest controlled study and the best scientific evidence on the subject at this time. Additionally, the anecdotal conclusions fail to identify other activities of equal risk. A peer-reviewed medical journal has reported the "beauty parlor stroke syndrome" in which the writer suggests that certain people with arterial defects may be more susceptible to stroke by hyperextending and their necks in a shampoo bowl.[2] Another study reports that abrupt changes in head position, such as rotating of the head when backing up a car, can increase risk of stroke in vulnerable patients[3]. Finally, evidence indicates that neck manipulation produces far less risk of serious side effects than: spine surgery[4]; the combined use of nonsteroidal anti-inflammatory drugs (NSAIDS) and aspirin[5]; and the use of aspirin alone[6].

I have discussed all of the above risks and benefits with the Practice, and, if applicable, have made an informed decision that the potential benefits outweigh the risks in my case.
I understand and accept that:

1. I have the right to withdraw from or discontinue any 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. I have signed this form AFTER reviewing my treatment plan with the Practice.

_____ _____

Witness Patient's Printed Name

_____

Patient's Signature

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[2] *The Lancet*, Volume 350, Issue 9093, Pages 1777 - 1778, 13 December 1997

[3] *Stroke*.1981; 12: 2-6

[4] Smith, JS et al. Rates and causes of mortality associated with spine surgery based on 108,419 procedures: a review of the Scoliosis - Research Society Morbidity and Mortality Database. Spine 2012, Nov 1;37(23):1975-82.3. Marquez-Lara A, Nandyala SV, Hassanzadeh H, Noureldin M, Sankaranarayanan S, Singh K: Sentinel Events in Cervical Spine
Surgery. Spine 2014 Jan 29 [Epub ahead of print], http://www.ncbi.nlm.nih.gov/pubmed/24480955

[5] Lanas A et al. A nationwide study of mortality associated with hospital admission due to severe gastrointestinal events and those
associated with nonsteroidal anti-inflammatory drug use. Am J Gastroenterology 2005, Aug;100(8):1685-93.

[6] Lanas A et al. A nationwide study of mortality associated with hospital admission due to severe gastrointestinal events and those
associated with nonsteroidal anti-inflammatory drug use. Am J Gastroenterology 2005, Aug;100(8):1685-93.