

# JointFit, PA Chiropractic & Sports Medicine Center Confidential Patient Information

3252 Kimball Ave Manhattan, KS Phone (785) 320-6868 Fax (785) 320-6861 Website: www.jointfitchiropractic.com

Office Use Only:  
Patient ID Number: \_\_\_\_\_  
Dr. Richard E Foveaux DC, MS, CSCS  
DX: \_\_\_\_\_,  
\_\_\_\_\_, \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient's Full Name \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Male  Female Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Married  Single  Widowed  Separated  Divorced Number of Children/Ages \_\_\_\_\_

Occupation: \_\_\_\_\_ Hours/Week \_\_\_\_\_ Employer: \_\_\_\_\_ Business Phone \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Employer: \_\_\_\_\_ Business Phone \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Family Physician: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Phone \_\_\_\_\_

Payment Method:  Cash  Check  MasterCard/Visa  Insurance Do You Have Health Insurance? \_\_\_\_\_

Primary Insurance Company \_\_\_\_\_ Insured's Name \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_ Insured's Name \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_

Previous Chiropractic Care:  Yes  No If Yes, for what Problem: \_\_\_\_\_

Doctor's Name \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Referred By (Friend, Relative, or Physician) : \_\_\_\_\_

Is Today's Visit Due To A Work Related Injury:  Yes  No

Is Today's Visit Due To A Personal Injury or Auto Accident:  Yes  No

(If yes to either questions above, please check with receptionist, additional information is needed)

Date Of Injury: \_\_\_\_\_

## AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release **any information** you deem appropriate concerning my physical or emotional condition and/or health history to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the **direct payment to you** of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated make payment to me or you based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services **refuses to make such payment** upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. However, it is understood that all reasonable efforts have been made to collect the sums due from the insurance company, or companies, contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what was due, I personally owe you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this state of Kansas.
5. I further agree that this Authorization and Assignment is irrevocable until all moneys owed JointFit, PA are paid in full.

Patient Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_



In general, would you say your health is (check one):  Excellent  Very good  Good  Fair  Poor

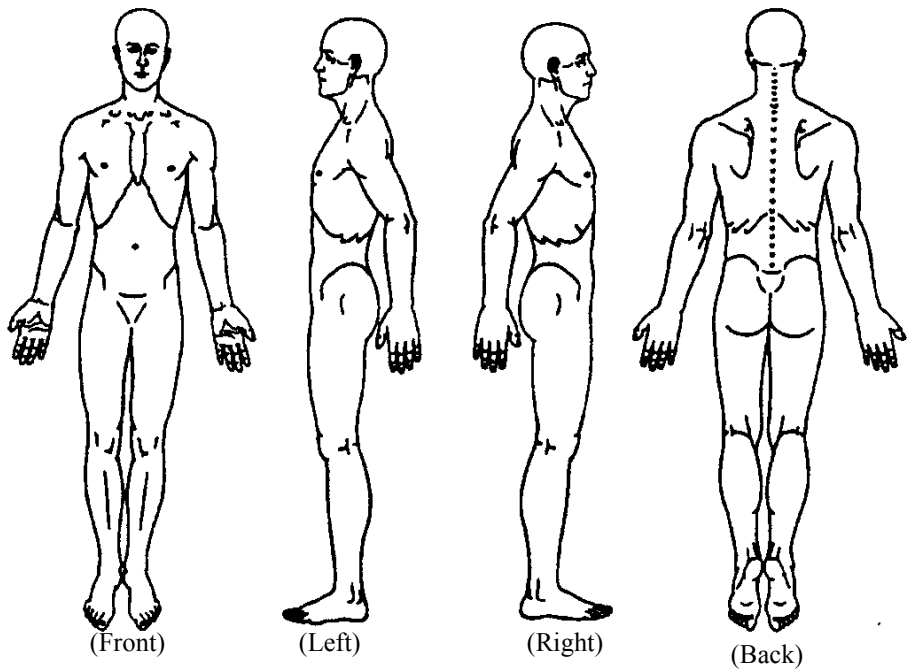
**PAST HEALTH HISTORY:**

- Have you ever experienced your present problem before for which you are consulting us:  Yes  No If yes, When: \_\_\_\_\_  
Was treatment provided:  Yes  No If yes, By whom: \_\_\_\_\_ Outcome: \_\_\_\_\_
- Have you **ever** had a **stroke** or issues with **blood clotting**?  Yes  No If yes, when: \_\_\_\_\_
- Have you recently experienced **dizziness**, unexplained **fatigue**, **weight loss**, or **blood loss**?  Yes  No If yes, explain: \_\_\_\_\_
- Have you **ever** had any **major illnesses, injuries, broken bones, hospitalizations, accidents, or surgeries**?  Yes  No

Date	Injury/Fracture/Illness/Surgeries	Treatment	Results

**PAIN CHART**  
Please Mark Areas of Pain using these Codes!

- +++ Burning
- ### Dull/Ache
- \*\*\* Numbness/Tingling
- === Throbbing
- 000 Stabbing/Sharp



**SEVERITY OF PAIN**

List region of pain and circle the number which represents the intensity of your pain.

- Complaint: \_\_\_\_\_
- Complaint: \_\_\_\_\_
- Complaint: \_\_\_\_\_



# INFORMED CONSENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I \_\_\_\_\_, Do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used.

Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor.

Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

## TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

## ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including, rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

**I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.**

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

_____ Signature of Patient	Date _____
_____ Signature of Parent or Guardian (if a minor)	Date _____
_____ Signature of Witness	Date _____

## JointFit, PA Chiropractic & Sports Medicine Center Financial/Privacy Policy and Disclaimer

### Insurance Verification

- **Insurance verification is not a guarantee of payment.** Verification is only a quote of patient benefits. Insurance companies review charges individually and make payment accordingly. **Charges not covered by insurance are the patient's responsibility and due within 30 days of billing.**

### Deductible Payments

- **It is our policy to collect at time of service.** Once we receive an "Explanation of Benefits" report from the patient's insurance company, we will bill or credit the account for the remaining balance. Reimbursement checks can be issued upon request.

### Collection of Patient Balance

- Co-payments and Co-insurance is the patient's responsibility and will be collected at the time of service.
- If the "Explanation of Benefits" report shows the patient has an outstanding balance from services not covered by the individual insurance company, patients will receive a bill outlining these outstanding charges. **Upon receipt, payment is due within 30 days. After 45 days, it is the clinic's policy to turn unpaid accounts over to a collections agency unless prior arrangements have been made.**

### Returned Checks

- It is our policy to collect \$35.00 for checks that are returned to us. This is to cover any fees that apply from the transaction

### Appointments

- If unable to keep an appointment, as a courtesy to our staff and other patients please give 24-hour notice. If it is a continual problem there will be a **\$20 charge** added towards your account each visit that is missed. The patient will be responsible for payment.

### Financial Policy Questions

- We are happy to address questions regarding your account at any time. Please direct accounting questions to our billing administrator, Jennifer Gilliam.

### HIPPA Privacy Policy

- Attached to the patient information packet at the back of these forms is the HIPPA Notice of Privacy Practices Policy for you.
- By signing below, the patient acknowledges that he/she has received the HIPPA Privacy Policy and that he/she understands and will comply with our financial policies.

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patient signature

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date

CHIROPRACTIC & SPORTS MEDICINE  
CENTER

**Schedule of Fees**  
As of 12/17/2009

Code	Description	Amount	Type of Charge
29280	Taping/Bracing Hand	\$5.00	Service
29540	Taping/Bracing Foot/Ankle/Leg	\$5.00	Service
97010	Warm Moist Heat or Icing	\$10.00	Service
97012	Mechanical Traction for Neck or Back	\$20.00	Service
97014	Electrical Stimulation of Muscle/Soft Tissue	\$20.00	Service
97035	Therapeutic Ultrasound	\$20.00	Service
97110	Therapeutic Exercise (Acute P.T. care)	\$35.00	Service
97112	Neuro-muscular Re-education Training	\$35.00	Service
97116	Gait Training	\$35.00	Service
97140	Manual Therapies (Trigger point work, mobilization, myofascial release)	\$35.00	Service
97504	Orthotic/Brace Fitting	\$6.00	Regular
97530	Therapeutic Activities (Advanced dynamic P.T. to improve function)	\$35.00	Service
97750	Physical Performance Test with Written Report	\$85.00	Service
98940	Spinal Manipulation (adjustment) 1-2 Regions	\$40.00	Service
98941	Spinal Manipulation (adjustment) 3-4 Regions	\$50.00	Service
98943	Spinal Manipulation (adjustment) 5 Regions	\$60.00	Service
98943	Extremity Manipulation (adjustment)	\$38.00	Service
99201	New Patient Focused Exam	\$45.00	Service
99202	New Patient Expanded Problem Focused Exam	\$60.00	Service
99203	New Patient Detailed Exam	\$80.00	Service
99204	New Patient Comprehensive Exam/Moderate Complexity	\$115.00	Service
99205	New Patient Comprehensive Exam/High Complexity	\$150.00	Service
99211	Existing Patient Minimal Exam	\$25.00	Service
99212	Existing Patient Problem Focused Exam	\$40.00	Service
99213	Existing Patient Expanded Exam	\$55.00	Service
99214	Existing Patient Detailed Exam	\$75.00	Service
99215	Existing Patient Comprehensive Exam	\$115.00	Service
A9300	Exercise Band	\$5.00	Patient
	Take Home Small Ice Pack	\$5.00	Patient
	Take Home Large Ice Pack	\$6.00	Patient
	Nutritional Supplements Vary By Product		Patient

I acknowledge that I have read and understand the fee schedule of JointFit, PA, that fees are based upon services performed, and that total visit fees may vary. I am responsible for payment for services that I receive or those that insurances may not fully cover. I understand that payment arrangements may be possible and I should inform Joint-Fit of financial difficulty prior to receiving services.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# HIPAA Notice of Privacy Practices

## JointFit, PA Chiropractic & Sports Medicine Center

**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.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

### **1. Uses and Disclosures of Protected Health Information**

#### **Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.**

**You may revoke this authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

## **Your Rights**

Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

## **Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy official of your complaint. **We will not retaliate against you for filing a complaint.** You can contact our privacy official at:

**HIPAA Privacy Official  
3252 Kimball Ave  
Manhattan, KS 66503**

This notice was published and became effective on before **November 2, 2009.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.