Ford Chiropractic, Inc.
1304 North Main Street – LaFayette, GA 30728

Today's Date ___/___/___ Signature of Patient _____

Patient Title: (circle one) Mr. Mrs. Ms. Miss Dr. Prof. Rev.

First Name: _____Nickname: _____ SSN#:_____-____-_____

Last Name: _____ Middle Name: _____Suffix: _____

Address 1: _____

Address 2: _____

City: _____State: _____ Zip Code: _____

Primary Phone: _____ Secondary Phone: _____

Mobile Phone:_____

Home Email: _____ Work Email: _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Date of Birth ___/___/___ Age: ____ Sex: (circle one) Male Female

Marital Status: (circle one) Single Married Other: _____

Occupation: _____

Race: (check one)

__White __Hispanic or Latino __Black/African American __Asian

__American Indian/Alaskan Native __Native Hawaiin/Pacific Islander

__Other _____ __Choose not to specify

Multi Racial: (circle one) Yes No Unknown

Preferred Language: (check one)

- English
- Spanish
- Other: _____

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Current Medications: (please include date you started taking the medication)
(if none, check here ___)

1) _____ 5) _____
2) _____ 6) _____
3) _____ 7) _____
4) _____ 8) _____

Are you currently pregnant or trying to become pregnant? (Circle one) Yes No

Allergies: (please include allergies to medications, skin allergies e.g. adhesives, latex, etc., food allergies, etc.)

_____
_____
_____

Briefly list your main health problems:

_____
_____

Has any doctor diagnosed you with HYPERTENSION presently? (circle one)
Yes No If yes, describe: _____

Has any doctor diagnosed you with DIABETES presently? (circle one)
Yes No If yes, what kind? Type I Type II

If yes to DIABETES, was your blood lab work test for hemoglobin A1c > 9.0%?
Yes No Not sure

If yes, other comments regarding your DIABETES? _____

Have you had an X-RAY or CT scan or MRI of your LOW BACK spine in the past 28 days?
Yes No

If yes, where was the procedure done?

_____

To be performed by clinic staff:

Height: ____ inches Weight: ____ pounds BP: _____/_____ Pulse: _____ O2: _____

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Name: _____ DOB: _____ Today's Date: _____

PAIN DESCRIPTORS

Place an X on the drawing to the right on the areas of pain and a **LETTER** describing the pain.

A = ACHE

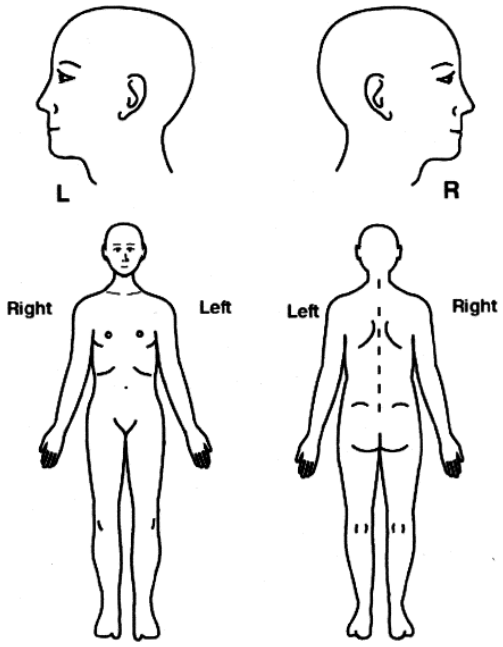
B = BURNING

S = SHARP

N = NUMBNESS

P = PINS & NEEDLES

R = RADIATING



NOTES: (DOCTOR USE ONLY)

_____
_____
_____
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_____
_____
_____
_____
_____
_____

TELL US A LITTLE MORE ABOUT YOUR PAIN

BODY PART	PAIN SCALE	CIRCLE FREQUENCY PAIN AFFECTS YOU
HEAD/NECK	0 1 2 3 4 5 6 7 8 9 10 NONE LITTLE MEDIUM SEVERE	25-50% 50-75% 75-100%
UPPER BACK	0 1 2 3 4 5 6 7 8 9 10 NONE LITTLE MEDIUM SEVERE	25-50% 50-75% 75-100%
LOWER BACK	0 1 2 3 4 5 6 7 8 9 10 NONE LITTLE MEDIUM SEVERE	25-50% 50-75% 75-100%

SURGERIES AND HOSPITALIZATIONS

DATE	SURGERY	REASON	RESULT

ALERT! _____
_____

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Welcome to our office! We are happy you have chosen Ford Chiropractic, Inc. for your healthcare needs. Your health is your greatest asset and therefore one of the best things you can invest in financially.

YOUR FIRST VISIT

All services rendered during the first visit MUST be paid for at that time. Whether you have insurance coverage, Medicare coverage, or no coverage at all, you may pay by cash, check, or credit card. If your insurance has not been verified by our office, you will be on a "cash" or "non-insurance" basis until coverage has been confirmed. If this results in an overpayment, we will credit your account or reimburse you when our office receives final payment from the carrier and care has been completed.

MANAGED CARE POLICIES (PPO, HMO, etc.) AND MEDICAL INSURANCE

If you have a managed care policy or medical insurance that our doctors are contracted with as a participating provider, you are responsible for all co-payments and non-covered services. Patients seeing the doctor for more than one visit per week are encouraged to make payment for all co-pays and non-covered services at the beginning of the week. This coverage is usually subject to the deductible and/or percentage co-pay (see below).

DEDUCTIBLE POLICIES

We gladly accept insurance assignment if the insurance company, 1) Verifies the deductible has been met, 2) Provides details of the available coverage, and 3) Agrees to make payment directly to our office. It must be understood by you, the patient, that insurance is an agreement between the patient and the insurance company. The agreement is not between the insurance company and Ford Chiropractic, Inc. unless we are in contract with your insurance company. In every case, the patient or their guardian is ultimately responsible for all fees with the exception of contracted deductions in which Ford Chiropractic, Inc. has agreed with your insurance company to take. In other words, if your insurance deductible has not been met, if your insurance company gives us the wrong information, or if your insurance company fails to pay for any reason, you are ultimately responsible.

TIME OF SERVICE PAYMENT (NON-INSURANCE)

A "time of service" discount is given for patients who choose to pay in full at the time services are rendered when not using health insurance or for patients that file their own insurance.

MEDICARE

Ford Chiropractic, Inc. does NOT accept assignment with Medicare. However, we do file the charges to Medicare for you. Medicare allows 12 adjustments per year. Medicare does NOT cover Exam, X-Rays, or Therapies. Medicare reimburses the patient directly when the service is approved. Medicare patients must pay for all services rendered at the time of service

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PAYMENT PLANS

Minimum payment required for our payment plan is 10% of any balance over $100 each week. Payments must continue until the entire balance is paid in full (even if you are no longer under active care). If you choose to participate in a payment plan, we will need to obtain a credit card number to keep on file or you may apply for care credit. Your credit card will only be used if you fail to make your regularly scheduled payment.

CARE CREDIT

Ford Chiropractic, Inc. offers an alternative to the "in-house" payment plan through Care Credit (funded by Synchrony Bank). Care Credit is a financial service that can be used at all participating physicians' offices, and most of the time, you can pay your balance with 0% interest. Please ask about applying for Care Credit if you are interested, and we will provide you with an information packet.

PAST DUE ACCOUNTS

Delinquent accounts will be sent to a collection agency that reports to major credit bureaus after we have exhausted all attempts to collect the balance.

AFTER HOURS / EMERGENCIES

Emergency care after hours, on weekends, or holidays is available. Please be aware that after hours calls are subject to additional charges and may not be covered by your insurance company. These charges are in addition to the services rendered, and you, the patient, will be solely responsible for payment.

Description of Service	Insurance	Non-Insurance	Medicare
Exam	$60.00	$60.00	N/A
X-Rays (per region: cervical, thoracic, lumbar, or extremities)	Minimum $40.00	Minimum $40.00	N/A
Adjustment	$45.00	$40.00	$40.00
Therapy (E-stim, Ultrasound, Hydrotherapy, Spinalator)	$20.00	$20.00	N/A
Spinal Decompression	$30.00	$30.00	N/A
Trigger Point Therapy (massage)	$35.00	$20.00	N/A

Check Acceptance Policy

By using a check for payment, you agree to the following terms: In the event your check is dishonored or returned for any reason, you authorize us to electronically (or by paper draft) re-present the check to your bank accountant for collection of the amount, plus any applicable fees permitted by law.

I have read, understand, and agree to the above stated policies of Ford Chiropractic, Inc.

Patient Signature Date

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Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-RAYS, on me (or on the patient named below for whom I am legally responsible) by the doctor(s) of chiropractic at Ford Chiropractic, Inc.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to: fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all the risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctors feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature: _____ Date:_____

Guardian Signature: _____ Date: _____

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PATIENT ELECTION TO SELF-PAY FOR NON-COVERED SERVICES

I, _____, the undersigned patient, acknowledge that I understand and agree that:

1. **Ford Chiropractic, Inc.** is a participating provider with most major insurance companies.

2. I am covered by one of the participating health insurance plans. (See your insurance plan or staff will check.)

3. The health plan under which I am covered includes benefits for some or all of the services provided by clinic.

4. Despite the above, I do not wish Ford Chiropractic, Inc. to submit a claim to my insurance company for services provided to me by Ford Chiropractic which exceed my visit maximum limit or are uncovered services.

5. Until such time as I may otherwise advise Ford Chiropractic, Inc. in writing, I elect to pay for the above specified uncovered services I receive from the clinic at their time of service rates.

6. By electing to self-pay for uncovered services, any payments I make to Ford Chiropractic, Inc. will not be credited toward satisfying any deductible I may be subject to under my health insurance plan.

7. I have read this Election to Self-Pay for Non-Covered Services form and have had the opportunity to ask any questions I may have had about the form. Any questions I may have had about this form have been answered to my satisfaction.

8. I have freely chosen to self-pay for uncovered services after having asked Ford Chiropractic, Inc. about payment options and having carefully considered those options.

Date:_____ Patient: _____

Signature of patient or responsible party if patient is a minor or is otherwise unable to sign for him/herself

_____

Printed name of responsible party and capacity of responsible party (e.g. parent, guardian, etc.)

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This notice describes how chiropractic and medical information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Ford Chiropractic, Inc., we may use or disclose personal and health related information about your care in the following ways:

1. Your personal health information, including your clinical records, may be disclosed to another health care provider of hospital if it is necessary to refer you for further diagnosis , assessment, or treatment.
2. Your medical records as well as your billing records may be disclosed to another party such as an insurance carrier, an HMO, a PPO, or your employer if they are responsible for the payment of your services.
3. Your name, address, phone number, and your medical records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.
4. We will use your health information to provide you with healthcare treatment and to coordinate or manage services with other healthcare providers, including third parties. We may disclose your health information to family members or friends, guardians, or personal representatives who are involved with your medical care.
5. We may disclose your health information in response to a court or administrative order, a valid subpoena, discovery request, civil/criminal proceedings, or other lawful processes.
6. We may release your health information for workers' compensation benefits or to similar programs to provide benefits for work-related injuries or illness.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment, we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outline above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home address or if you would like the information in a different form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for ten years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy, or amend your health related information should be provided to us in writing.
We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, privacy practices, or any aspect of our privacy activities, you should direct your complaint to: Dr. Aaron Ford.

This notice is effective April 14, 2003. This notice and any alterations or amendments made hereto will expire ten years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

I hereby authorize the following: (Please initial all that apply.)

____ Release of medical information to other medical providers, by phone, in person, or by mail as necessary for continued care process.

____ Release of medical information to other medical providers, as necessary, VIA FAX as requested them.
____ Release of medical information, as necessary, VIA FAX, INTEROFFICE COURIER, IN PERSON, OR BY MAIL for claims/billing processes.

____ Voicemail and text messages on my personal phone/answering on my personal phone/ answering machine regarding appointments/callbacks, etc.

____ I authorize, as necessary, test results, appointments, etc. to be given to _____ who is my _____ (relationship to person named) in my absence at the phone number _____.

Patient Name (Printed): _____

Patient Signature: _____ Date: _____

If you are a minor or if you are being represented by another party:

Personal Representative (Printed): _____
Personal Representative Signature: _____Date: _____

Authorization:
I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____
Patient Signature (or parent/guardian if minor) Date