Acacia Chiropractic & Acupuncture P.C.
3088 Flora Rd. Belvidere, IL 61008
www.AcaciaChiropracticAndAcupuncture.com

Dr. Danielle Anderson
Danielle.Anderson.DC@gmail.com
815-519-3686

## INFORMED CONSENT AND AUTHORIZATION TO TREAT

**Please read and sign the informed consent. This must be read and signed prior to the doctor performing an examination. If you have any questions or concerns, please address them to the doctor.**

**CHIROPRACTIC:**

Doctors of Chiropractic (D.C.) who use manual therapy techniques such as spinal adjustments are required to advise patients that there may be some risks associated with such treatment.

a) While rare, some patients have experienced rib fractures, or muscle and ligament strains or sprains following spinal adjustments.

b) Some types of spinal adjustments of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Stroke has been the subject of tremendous disagreement within and without the profession, with prominent authority saying that there is at most a one-in-a-million chance of such an outcome. We employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury.

c) There have been rare reported cases of disc injuries following neck or low back adjustments although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustments, has been the subject of government reports and multidisciplinary studies conducted over many years and have been demonstrated to be highly effective in treating spinal pain, headaches and other symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

☐_____ **PLEASE INITIAL AFTER READING**

**I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on the doctor to exercise judgment during the course of treatment which the doctor feels at the time, based upon the facts then known, are in my best interests. I understand that the results are not guaranteed. I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of the chiropractic treatment (may include spinal adjustments &/or acupuncture) as well as the contents of this Consent. I consent to the treatments recommended to me by my chiropractor.**

Patient Name (Print):_____ Date:_____

Patient Signature:_____

☐_____ **PLEASE INITIAL AFTER READING**

**ACUPUNCTURE:**

I understand and am informed that in the practice of acupuncture there are some risks to treatment, including but not limited to, minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, shock, convulsions, and stuck or bent needles. I have been advised that only sterilized needles will be used. All acupuncture needles are properly disposed of after each and every treatment**.**

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## CONFIDENTIAL PATIENT INFORMATION

Today's Date_____

First Name_____ M.I._____ Last Name_____
Address_____ Unit #_____ City_____
State_____ Zip_____ Birth Date (mm/dd/yyyy)_____ Age_____ Sex: ☐M ☐F
Social Security Number_____-_____-_____ Home # (_____)_____
Cell # (_____)_____ E-mail_____
Which phone # would you prefer us to contact you with? ☐Home ☐Work ☐Cell ☐Other # (_____)_____
How would you like to receive appointment reminders ☐ Text ☐E-mail ☐ Phone Call

Marital Status: ☐Single ☐Married ☐Other Spouse Name_____ # of Children_____
Occupation (optional)_____ Employer (optional)_____
Spouse Occupation (optional)_____ Spouse Employer (optional)_____
Name of Family Doctor_____ Family Doctor # (_____)_____
When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? ☐Y ☐N
How did you find us?_____

## INSURANCE INFORMATION

How will you be paying for today's visit? ☐Cash ☐Check ☐Credit Card
(there are additional fees for credit card transactions)

Please ✓ all insurance coverage that may be applicable in this case**:**
☐Major Medical ☐Auto Accident ☐Worker's Compensation ☐Medicare ☐Flex Plans ☐Other_____

## AUTHORIZATION AND RELEASE

I authorize payment of insurance benefits directly to this chiropractic office. I authorize the doctor to release all information necessary to communicate with personal healthcare providers, payors and to secure the payment of benefits. I understand that I am responsible for all costs of my care, regardless of insurance coverage. I also understand that if I terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. Balances held over for more than 30 days are subject to a rebilling fee. I am also responsible for notifying this office of any changes (insurance, billing address, phone etc.)

Patient Name (Print):_____ Date:_____

Patient Signature:_____

**MISSED APPOINTMENT / CANCELLATION POLICY:** We make every effort to accommodate your scheduling needs. In return we ask that you keep your scheduled appointments or notify us in advance if for any reason you are unable to keep your appointment. We request a 24 hour notice in order to reschedule or cancel your appointment. A **$30** fee will be charged if you miss or cancel your appointment without a 24 hour notice. The missed appointment fee is NOT covered by insurance and is your responsibility to pay. If you are 10 or more minutes late to your appointment, it may have to be rescheduled.

Patient Name (Print):_____Date:_____

Patient Signature:_____

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## CREDIT GUARANTEE

**As the recipient of services from Acacia Chiropractic and Acupuncture P.C. you are ultimately responsible for payment for all services provided. In order for our office to bill your Insurance Plan, you must provide your credit card information below. Your credit card information will be kept on file. Our office will submit a claim one (1) time to your above listed Health Insurance Provider. It is thereafter *your responsibility* to ensure that your health insurance pays your bill for services. If payment is not received in full within sixty (60) days after submission, by providing your card below and receiving provided services, you are authorizing Acacia Chiropractic and Acupuncture P.C. to charge your provided credit card for any unpaid bills or claims. Without a card on file, payment is due IN FULL at the time all services are rendered. Any claims paid after your credit card has been billed will be refunded to the patient. Balances held over for more than 30 days are subject to a rebilling fee. There is a Credit Card processing fee of $4 if processed manually and $2 when the card is present when processed. Non-insurance patients carrying over any balance must have a credit card on file.**

**CREDIT CARD:** ☐VISA ☐Master Card ☐DISCOVER ☐FLEX SPENDING CARD

**CREDIT CARD #:** _____ **EXPIRATION DATE:** _____ **SEC. CODE:**_____

**CARD HOLDER SIGNATURE:** _____ **DATE:** _____ **BILLING ZIP CODE:**_____

## FINANCIAL POLICY FOR PATIENTS WITH HEALTH INSURANCE

**Patient Name:** _____
**LAST** **LEGAL FIRST** **MI**

Name of Insured **Primary**: _____
(if different from patient) LAST LEGAL FIRST MI DATE OF BIRTH

Name of Insured **Secondary**: _____
(if different from patient) LAST LEGAL FIRST MI DATE OF BIRTH

**Acacia Chiropractic and Acupuncture P.C.** is "In-Network" with Blue Cross/Blue Shield PPO, United Healthcare PPO, & Medicare plans only. All other insurance plans are considered "Out-of-Network".

**For "In-Network" Insurance Plans**. All co-payments, co-insurance, deductibles and non-covered services are due at the time of service. We will submit a claim one time on the patient's behalf. You are responsible for payment of all services your insurance company may deny or fail to pay.

**For "Out-of-Network" Insurance Plans**. Payments for all services are due in full at the time services are provided. Acacia Chiropractic & Acupuncture P.C. is under no obligation to pursue reimbursement on the patient's behalf.

## AUTHORIZATION (to release information & settle appeals or disputes) AND ASSIGNMENT (of benefits to doctor)

I hereby authorize the doctor to release all medical information necessary to process any insurance claims. 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 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. 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.

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 Health Insurance Provider, and hereby assign and convey directly to Acacia Chiropractic and Acupuncture P.C., all 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.

**SIGNATURE OF PATIENT/GUARDIAN**: _____ **DATE**: _____

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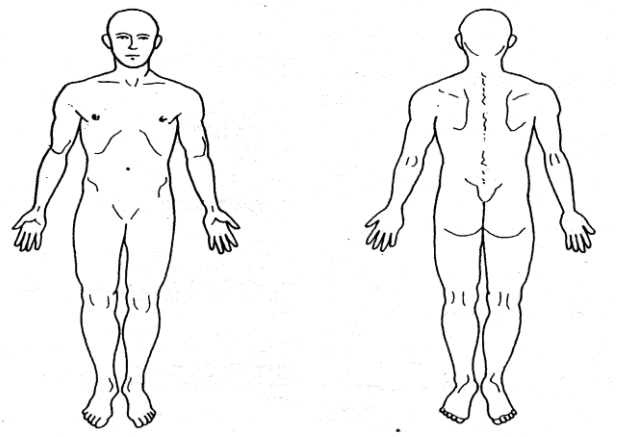
## PRESENT MEDICAL HISTORY

Purpose of today's visit:_____
Date symptoms appeared or accident happened:_____
Is present illness due to: ☐Auto ☐Work ☐Illness ☐Unknown ☐Other (describe)_____
Have you ever had the same or a similar condition? ☐Y ☐N If yes, when:_____
Days lost from work:_____ Last physical exam (date):_____

**Describe each PAIN or SYMPTOM** that you are having and **place ✓ on the SEVERITY OF PAIN SCALE** to indicate the level of discomfort that the pain/symptom creates. **1 = No pain** and **10 = Worst pain ever.**

| **PAIN or SYMPTOM DESCRIPTION:** | **SEVERITY OF PAIN SCALE:** |
|---|---|
| 1._____ | ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 |
| 2._____ | ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 |
| 3._____ | ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 |

**PAIN DRAWING:** Mark your painful spots on the picture. If your pain radiates, draw an arrow from where it starts to where it stops. Use the appropriate symbols to describe the pain.
**Ache > > > Burning x x x Numbness = = = Pins/Needles o o o Stabbing / / / Throbbing ~ ~ ~**



Symptoms occur in: ☐Morning ☐Afternoon ☐Night ☐Consistently ☐Come & Go ☐Other
Symptoms have persisted for (number): ____Hours ____Days ____Weeks ____Months ___Years

Check the following activities that **AGGRAVATE YOUR CONDITION:**
☐Bending ☐Coughing ☐Lifting ☐Lying ☐Reaching ☐Sitting ☐Sneezing
☐Standing ☐Turning Head ☐Walking ☐Straining at Stool ☐Other_____

Check the following activities that **RELIEVE YOUR CONDITION:**
☐Bending ☐Lifting ☐Lying ☐Reaching ☐Sitting ☐Standing ☐Turning Head
☐Walking ☐Stretching ☐Self Massage ☐Cold Pack ☐Hot Pack ☐Other_____

Do your symptoms &/or pain limit you from completing your activities of daily living?
☐No ☐Yes _____
What are your goals for your treatment?
_____

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## PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from: (Place ✓ by the conditions that apply to you)

| | | | |
|---|---|---|---|
| ☐Abdominal Pain | ☐Cold hands/feet | ☐Hand Pain | ☐Pacemaker |
| ☐Acid Reflux | ☐Congenital Diseases | ☐Headaches | ☐Rheumatoid Arthritis |
| ☐Alcoholism | ☐ Constipation | ☐Heart Attack | ☐Seizures |
| ☐Allergies | ☐COPD | ☐High Cholesterol | ☐Shortness of Breath |
| ☐Ankle Pain | ☐ Depression | ☐High/Low Blood Pressure | ☐Shoulder Pain |
| ☐Asthma | ☐Diabetes | ☐Hip Pain | ☐Stroke |
| ☐Anxiety | ☐Diarrhea | ☐HIV Positive | ☐Ulcers |
| ☐Back Pain | ☐Dizziness | ☐Insomnia | ☐Wrist Pain |
| ☐Blurred Vision | ☐Drug Addiction | ☐Joint Replacement | ☐Other_____ |
| ☐Buzzing in Ears | ☐Eating Disorder | ☐Knee Pain | _____ |
| ☐Cancer | ☐Elbow Pain | ☐Light bothers eyes | |
| ☐Carpal Tunnel | ☐Epilepsy | ☐Loss of Balance | |
| ☐Chest pain | ☐Excessive Bleeding | ☐Muscle Jerking | |
| ☐ Chronic Fatigue | ☐Foot Pain | ☐Neck Pain | |
| ☐ Circulatory Problems | ☐Fractured Bones | ☐Osteoarthritis | |

0Do you have a history of Stroke or Hypertension? ☐Y ☐N Describe_____

Have you had any major illnesses, injuries, car accidents, surgeries, or hospitalizations (include dates)? **Women,** include information about childbirths_____

_____

_____

Date of last physical exam _____

Are you taking any medications/drugs? ☐Y ☐N Describe_____

Do you have any allergies? ☐Y ☐N Describe_____

Have you been treated by a physician for any health condition in the last year? ☐Y ☐N

Describe condition(s)_____

Please list any other health problems you have, no matter how insignificant they may be:

_____

**Women:** Any menstrual difficulties? ☐Y ☐N Describe_____

Are you pregnant? ☐Y ☐N Last Period (date)_____

Last Pap (date)_____ Last Mammogram (date)_____

## SOCIAL HISTORY

Do you drink alcohol? ☐Y ☐N Drinks per week_____

Do you smoke? ☐Y ☐N Packs per day_____

Do you drink caffeine? ☐Y ☐N Drinks per day_____

Do you take vitamin supplements? ☐Y ☐N Describe_____

Do you exercise? ☐Y ☐N Frequency and type of activity_____

List personal hobbies:_____

What percentage of time during the day (at home or at work) do you spend:

At computer____ Bending____ Lifting____ Pulling____ Pushing____ Sitting____ Standing____

## FAMILY HISTORY

**FAMILY DISEASES** Indicate whether **F**ather, **M**other, **S**ister, **B**rother, if applicable:

| | | | |
|---|---|---|---|
| _____Arthritis | _____Chest Pain | _____Liver Disease | _____Reproductive Disorders |
| _____Asthma | _____Diabetes | _____Lung Disease | _____Stroke |
| _____Back Pain | _____Heart Disease | _____Mental Illness | _____Thyroid Disease |
| _____Cancer | _____Kidney Disease | _____Muscular Dystrophy | _____Tuberculosis |

Other Diseases_____

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# HIPAA NOTICE OF PRIVACY PRACTICES

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 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.

**NO CONSENT REQUIRED**

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

(a) 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.

(b) 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.

(c) 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.

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

(a) De-identified Information - Information that does not identify you and, even without your name, cannot be used to identify you.

(b) 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 a billing company that assists the office in submitting claims for payment to insurance companies or other payers.

(c) Personal Representative - To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) 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.

(e) 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.

(f) 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.

(g) 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.

(h) 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.

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(i) 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.

(j) 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.

(k) 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.

(l) 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.

(m) 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.

(n) 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.

(o) 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.

**Appointment Reminders**

- Your health care provider or a staff member may disclose your health information to contact you to provide appointment reminders. If you are not at home to receive an appointment reminder, a message will be left on your answering machine, voice mail, or with the person who answers the call.

- You have the right to refuse us authorization to contact you to provide appointment reminders. If you refuse us authorization, it will not affect the treatment we provide to you.

**Family/Friends**

The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care unless you direct the Practice to the contrary. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

- (a) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment that you do not object to the use or disclosure.

- (b) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

**AUTHORIZATION**

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

**Your Right to Revoke Your Authorization**

You may revoke your authorization to us at any time; however, your revocation must be in writing.

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**Restrictions**

You may request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment

**You Have a Right to**

Inspect and obtain a copy your PHI as provided by 45 CFR 164.524. To inspect and copy your PHI, you are requested to submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request.

Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

Prohibit report of any test, examination or treatment to your health plan or anyone else for which you pay in cash or by credit card.

Receive an accounting of disclosures of your PHI as provided by 45 CFR 164.528. The request should indicate in what form you want the list (such as a paper or electronic copy)

Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.

Request copies of your PHI in electronic format if this office maintains your records in that format.

Amend your PHI as provided by 45 CFR 164.528. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.

Receive notice of any breach of confidentiality of your PHI by the Practice

Complain to the Practice or to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201, 202 619-0257, email: ocrmail@hhs.gov if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

**PRACTICE'S REQUIREMENTS**

1. The Practice:

- Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
- Is required to abide by the terms of this Privacy Notice.
- Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
- Will distribute any revised Privacy Notice to you prior to implementation.
- Will not retaliate against you for filing a complaint.

Patient Signature:_____ Date: _____