CHIROPRACTIC
LAKE MERIDIAN
P.S.

PATIENT REGISTRATION FORM

Name _____MI _____ Last Name _____
Preferred Name _____ DOB _____

Marital Status: ___ Single ___Married ___Separated ___Divorced ___Widowed
Employment Status: ___Full-Time ___ Part-Time ___Self Employed ___ Active Duty ___Disabled ___None

Patient Employer _____ Phone _____
Address _____ City _____State _____Zip _____

How did you hear about us? ___Doctor ___Insurance plan ___Sign ___Website ___Fried ___Family member ___Other

Whom may we thank for referring you? _____

Primary Care Physician _____Phone_____

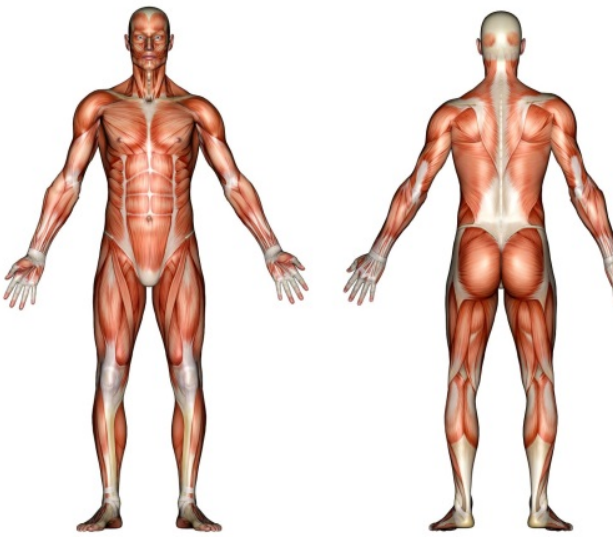
Emergency contact name _____ Phone_____
Relationship _____
Address _____City_____State_____ Zip_____

Minor Consent: I authorize Lake Meridian to provide treatment for the minor listed above.
Parent Guardian _____Signature_____

Patient's Auto Insurance Name _____
- Phone #_____ Claim # _____

Other Driver Information: Name _____
- Address _____ City _____State _____Zip _____
- Drivers Ins. Co. _____
- Ins Co. phone # _____
- Claim # _____

Please mark on the diagram areas of concern:



Attorney Name :_____
- Phone # _____

Labor & Industries
- Date of Injury:_____
- Claim # _____

Primary Insurance Name:_____
ID # _____

Secondary Insurance Name:_____
ID # _____

Patient Signature_____
Date_____

CHIROPRACTIC
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Protected Health Information Consent Form (HIPAA)

We want you to know how we protect your health information at our clinic and your rights concerning those records. 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.

1. The Patient understands and agrees to allow the clinic to use their Protected Health Information (PHI) for the purpose of treatment, payment, health care operation, and coordination of care. Individuals who may receive and use the disclosed information included, but are not limited to, other health care providers (including chiropractors, medical doctors, nurses, etc., attorneys, insurance companies (including Medicare), radiologists, and social services agencies. The patient's PHI may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules.

2. Individuals affiliated with our clinic who may use or disclose this information include Front and Business Office Staff, Physicians, Chiropractic Assistants, Massage Therapists, Information Technology Personnel, the Privacy Official, and the Compliance Officer.

3. 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 the clinic to assure that your records are not readily available to those who do not need them.

4. The patient understands that the Front Desk and Business Office are open areas and are not completely secure.

5. The patient grants the clinic permission to communicate with him or her through the use of phone calls, emails, postcards, greeting cards, notices of special events, and educational correspondence.

6. 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 what disclosures have been made and submit, in writing, any further restrictions of the use of the PHI. The clinic is not required to agree to those restrictions but, if we do, we shall honor that agreement.

7. A patient's written consent need only be obtained one time for all subsequent care given the patient at the clinic.

8. Patients have the right to file a formal complaint with the clinic privacy official about any possible violation of these policies and procedures.

9. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operation, the clinic has the right to refuse to provide care.

Whom of your family or friends would you allow us to release information to? Without your consent we cannot.

Name _____ Relation _____

Name _____ Relation _____

By signing this form, you consent to our use and disclosure of PHI about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Clinic provides this form to comply with HIPAA.

_____ _____

Patient's Signature Date

_____ _____

Patient's Signature (if patient is a minor) Date

_____ _____

Witness Date

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustment may be a vertebral artery injury that could lead to stroke.

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 are 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 my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustment, as reported following my assessment.

_____

Patient Name (printed) Relationship to patient

_____

Patient or legal Guardian signature **Date**

_____

Witness Signature (office staff) **Date**

Standard authorization of use and disclosure of protected health information

Information to be Used or Disclosed

The information covered by this authorization will be used or disclosed by Lake Meridian Chiropractic and it's patients includes:

*Your Birthday in the office ---
*Thanking you for a referral in the office and in the newsletter
*Success Story in the office & newsletter

Expiration Date of Authorization:

This authorization is effective through 04/16/2028 unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization:

You may revoke or terminate this authorization at any time.

Potential for Re-disclosure:

Information that is disclosed under this authorization may be disclosed again by the person or organization.
The privacy of this information may not be protected under the federal privacy regulation.

Name of Patient (Print or Type) _____

Signature of Patient _____Date _____

LAKE MERIDIAN CHIROPRACTIC, PS FINANCIAL POLICY

We are doing everything possible to hold down the cost of medical care. You can help a great deal by eliminating the need for us to bill you. The following is a summary of our payment policy.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

For your convenience, we offer the following methods of payment: cash, check, VISA, MasterCard, Discover and debit cards. There is a $35 service charge for returned checks. Payment is required at the time services are rendered; this includes deductibles, co-pays and non-covered services. A 1% rebilling fee will be added to any unpaid balance remaining after 45 days. Failure to keep this account current may result in failure to provide additional services.

INSURANCE:

We bill participating insurance companies as a courtesy to you. Please remember that your insurance is a contract between you and your insurance company. You will be responsible for amounts not paid by your insurance company including your estimated percentage/copay, deductibles and non-covered services at the time the services are rendered. The actual amount paid cannot be determined until your insurance company processes the claim. If we have not received payment from your insurance company within 60 days of date of service, you will be expected to pay the balance in full.

AUTOMOBILE ACCIDENTS:

We will bill your personal injury protection (PIP) insurance if you have it. You must contact your automobile insurance and get a claim number to us and follow up with filling out a PIP application. If you don't have PIP, we will bill your health insurance, if they allow it. You are still responsible at the time of service for your co-payments and deductibles as usual. The exception to this is if you retain an attorney as described below. If you don't have PIP or health insurance, but would like us to hold your bill until settlement, you must retain an attorney who will give us a letter of guarantee they will pay your balance at the time of settlement AND there is a 1% monthly finance charge for holding the balance until settlement.

MEDICARE:

Lake Meridian Chiropractic, PS is a "non-participating" provider with Medicare. You are required to pay for all services at the time they are rendered. We will bill Medicare for you and you will receive reimbursement from them on covered services. Generally Medicare bills your secondary insurance, if they do not, notify us, bring us your EOB from Medicare and we will file your secondary for you as a courtesy.

LABOR & INDUSTRIES OR "ON-THE-JOB" INJURY:

We must have verification that your claim has been accepted in order to bill L&I, otherwise your health insurance will be billed or you will need to pay at the time of service if you have no health insurance.

NO INSURANCE, SELF PAY OR MAXED BENEFITS ON INSURANCE:

We will gladly give a time of service (TOS) discount for services rendered and paid on the same day. We will keep a credit card on file for family members to use at the time of service so they can receive the TOS discount should they want to.

REFUNDS:

Overpayments will be refunded once the amount due is confirmed by the billing department.

If you are unable to meet these requirements, we will gladly discuss alternative payment programs before services are rendered.

Assignment and Release:

I hereby authorize that my insurance benefits be paid directly to the doctor. I am financially responsible for any balance due. I authorize the doctor or the insurance company to release any information required to approve this claim. I have read and understand the above financial policy and agree to the requirements as stated.

Patient_____ Date_____