



## Patient Information

Name:		Today's Date:	
Address:	City:	State:	Zip:
Home Phone:	Work Phone:	Mobile Phone:	
Email Address:	Race:	Ethnicity (Check One): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
Employer:	Occupation:		
Work Address:			
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Age:	Birth Date:	
Patient SS#:			
Spouse Name:	Children Names/Ages:		
Insured Date Of Birth:			
Would You Like to Receive Appointment Reminders? (Check one or both) <input type="checkbox"/> Text Message on your Mobile Phone <input type="checkbox"/> Email			
Mobile Phone Carrier (to receive appointment reminders via text message) Circle One: Alltel AT&T Cellular One Nextel Qwest Sprint T-Mobile Verizon Virgin Mobile US Cellular Other: _____			
Whom may we thank for referring you?			

## Patient Condition

Reason for visit:	
Desired Service: <input type="checkbox"/> Chiropractic <input type="checkbox"/> Acupuncture <input type="checkbox"/> Massage <input type="checkbox"/> Nutrition	
When did symptoms first appear?	
Is the condition getting progressively worse? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Does it interfere with your: <input type="checkbox"/> work <input type="checkbox"/> sleep <input type="checkbox"/> daily routines <input type="checkbox"/> recreation	
Activities which are painful: <input type="checkbox"/> standing <input type="checkbox"/> sitting <input type="checkbox"/> lying down <input type="checkbox"/> walking <input type="checkbox"/> bending	
Using the appropriate symbol, mark on the picture where you continue to have: Pain (X), Numbness (/), or Tingling (#)	
How would you describe your pain? Mark all that apply:  <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Throbbing <input type="checkbox"/> Aching <input type="checkbox"/> Shooting <input type="checkbox"/> Burning <input type="checkbox"/> Stiffness <input type="checkbox"/> Cramping <input type="checkbox"/> Other	
Is the pain: <input type="checkbox"/> Constant <input type="checkbox"/> Come and Go	
Have you had similar pain in the past and when?	

# Paun Family Chiropractic and Wellness, P.C.

## Consent Form

Effective Date: December 2014

**Please read each section and sign below, even if you are not receiving chiropractic care.**

**Health:** a state of optimal physical, mental, and social well-being, not merely the absence of disease.

The most common therapeutic procedure performed by doctors of chiropractic is known as “spinal manipulation,” also called “chiropractic adjustment.” The purpose of manipulation is to restore joint mobility by manually applying a controlled force into joints that have become hypomobile – or restricted in their proper movement – as a result of a tissue injury. Tissue injury can be caused by a single traumatic event, such as improper lifting of a heavy object, or through repetitive stresses, such as sitting in an awkward position with poor spinal posture for an extended period of time. In either case, injured tissues undergo physical and chemical changes that can cause inflammation, pain, and diminished function for the sufferer. Manipulation, or adjustment of the affected joint (as well as the use of other modalities) and tissues restores mobility, thereby alleviated pain and muscle tightness, and allowing tissue to heal.

### **The material risks inherent in Chiropractic adjustment.**

As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include: fractures, dislocations, muscle strain, costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

### **The probability of those risks occurring.**

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the timing of your history and during the examination. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest (or said minor's interest) to undergo the treatment recommended. Having been informed of the risks, I hereby authorize the Doctor to examine, perform diagnostic studies and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

**All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.**

**Patient/Guardian Signature:** \_\_\_\_\_

**(Date)** \_\_\_\_\_

Paun Family Chiropractic and Wellness, P.C.

**Assignment of Benefits – Financial Responsibility**

Effective Date: December 2014

I hereby request that payment of authorized Medicare and all other third party insurance/payor benefits be made directly to Paun Family Chiropractic and Wellness, P.C. (PFCW) for any services furnished to me by that supplier. I hereby assign payment for services provided to me by PFCW are made directly to PFCW. I understand that I am financially responsible for any co- payments, deductibles and non-covered services. PFCW accepts assignment on all Medicare/pay or covered services/supplies unless otherwise notified. I further acknowledge that any benefits paid directly to the beneficiary for services provided by PFCW will be endorsed and delivered/mailed to PFCW within 10 days of receipt.

If, for any reason, you have an account in arrears with our office and we are not able to establish a repayment plan, your account will be sent to collections. This is used only as a last resort by this office. If this option must be used, a 20% fee will be added to your account to help with the fees incurred by this office. We will always work with you to get your account paid in full. If collections procedures fail to produce payment on your account, further action will be pursued in Small Claims Court, and any court and/or attorneys fees will be your responsibility. Any returned checks will be assessed a fee of \$25.70 or 5% of the check amount, whichever is greater, in accordance with State of Indiana regulations. If payment arrangements are not established with our office within a reasonable amount of time (within 12 days of notice sent by our office), further action will be pursued through the Prosecutors' Office to recoup our costs.

I understand that my signature requests that payment by my insurance carrier be made directly to PFCW and that I am responsible for co-payments, deductibles and non-covered services.

**I have read and fully understand the above statements.**

**Patient/Guardian Signature:** \_\_\_\_\_

**(Date)** \_\_\_\_\_

# Paun Family Chiropractic and Wellness, P.C.

## Privacy Notice

Effective Date: December 2014

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.**

This Notice of Privacy (NOP) 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 PHI. "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 condition and related health care services.

### **USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**

**Treatment:** We may use and disclose your personal information to provide you with treatment or services. For example, we may use your health information to prescribe a course of treatment or make a referral. We will record your current healthcare information in a record so, in the future, we can see your medical history to help in diagnosing and treatment, or to determine how well you are responding to treatment. We may provide your health information to other health providers, such as referring or specialist physicians, to assist in your treatment. Should you ever be hospitalized, we may provide the hospital or its staff with the health information it requires to provide you with effective treatment.

**Payment:** We may use and disclose your health information so that we may bill and collect payment for the services that we provided to you. For example, we may contact your health insurer to verify your eligibility for benefits, and may need to disclose to it some details of your medical condition or expected course of treatment. We may use or disclose your information so that a bill may be sent to you, your health insurer, or a family member. The information on or accompanying the bill may include information that identifies you and your diagnosis, as well as services rendered, any procedures performed, and supplies used. Also, we may provide health information to another health care provider, such as an ambulance company that transported you to our office, to assist in their billing and collection efforts.

**Health Care Operations:** We may use and disclose your health information to assist in the operation of our practice. For example, members of our staff may use information in your health record to assess the care and outcomes in your case and others like it as part of a continuous effort to improve the quality and effectiveness of the healthcare and services we provide. We may use and disclose your health information to conduct cost- management and business planning activities for our practice. We may also provide such information to other health care entities for their health care operations. For example, we may provide information to your health insurer for its quality review purposes.

**Other Permitted and Required Uses and Disclosure** will be made **only** with your consent, authorization or opportunity to object unless required by law. You may revoke the 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 HEALTH INFORMATION RIGHTS**

The following are statements of your rights with respect to your protected health information:

**Right to Obtain a Paper Copy of This Notice:** You have the right to a paper copy of this Notice of Privacy Practices at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy.

**Right to Inspect and Copy:** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. You have a right to information that is stored electronically that is not in EHR software, including information stored in MS Word, Excel, PDF, plain text and other electronic formats. To inspect and copy medical information, you must submit a written request to our privacy officer. We will supply you with a form for such a request. If you request a copy of your **medical information, we may** charge a reasonable fee for the costs of labor, postage, and supplies associated with your request. We may not charge you a fee if you require your medical information for a

claim for benefits under the Social Security Act or any other state or federal needs- based benefit program. If your medical information is maintained in an electronic health record, you also have the right to request that an electronic copy of your record be sent to you or to another individual or entity. We may charge you a reasonable cost based fee limited to the labor costs associated with transmitting the electronic health record. You have a right to have this information with-in 30 days of receipt of your request.

**Right to Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we retain the information. To request an amendment, your request must be made in writing and submitted to our privacy officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the medical information kept by or for [name of provider];
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

If we deny your request for amendment, you may submit a statement of disagreement. We may reasonably limit the length of this statement. Your letter of disagreement will be included in your medical record, but we may also include a rebuttal statement.

**Right to an Accounting of Disclosures:** You have the right to request an accounting of disclosures of your health information made by us. In your accounting, we are not required to list certain disclosures, including:

- disclosures made for treatment, payment, and health care operations purposes or disclosures made incidental to treatment, payment, and health care operations, however, if the disclosures were made through an electronic health record, you have the right to request an accounting for such disclosures that were made during the previous 3 years;
- disclosures made pursuant to your authorization;
- disclosures made to create a limited data set;
- disclosures made directly to you.

To request an accounting of disclosures, you must submit your request in writing to our privacy officer. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you would like the accounting of disclosures (for example, on paper or electronically by email). The first accounting of disclosures you request within any 12 month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting of disclosures. We will notify you of the costs involved and you may choose to withdraw or modify your request at that time, before any costs are incurred. Under limited circumstances mandated by federal and state law, we may temporarily deny your request for an accounting of disclosures.

**Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we communicate about you to someone who is involved in your care or the payment for your care. You have a right to restrict certain disclosures of Protected Health Information to a health plan where you have paid out of pocket in full for the healthcare item or service. As noted above, we are not required to agree to your request. If we do agree, we will comply with your request unless the restricted information is needed to provide you with emergency treatment. To request restrictions, you must make your request in writing to our privacy officer. In your request, you must tell us what information you want to limit, whether you want to limit our use, disclosure, or both and to whom you want the limits to apply.

**Right to Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by e- mail. To request confidential communications, you must make your request in writing to our privacy officer. We will accommodate all reasonable requests.

**Right to Receive Notice of a Breach:** We are required to notify you by first class mail or by email (if you have indicated a preference to receive information by e- mail), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users.

**COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. **We will not retaliate against you for filing a complaint.** To file a complaint with us, contact our privacy officer at the address listed above. All complaints must be submitted in writing and should be submitted within 180 days of when you knew or should have known that the alleged violation occurred.

**APPOINTMENT REMINDERS**

We may use and disclose Information in your medical record to contact you as a reminder that you have an appointment at [name of provider]. We usually will call you at home the day before your appointment and leave a message for you on your answering machine or with an individual who responds to our telephone call. However, you may request that we provide such reminders only in a certain way or only at a certain place. We will endeavor to accommodate all reasonable requests.

**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 protect health information. We are also to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.**

*By signing this Agreement, you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.*

Signature: \_\_\_\_\_

Date \_\_\_\_\_

Print Name: \_\_\_\_\_

# Paun Family Chiropractic and Wellness, P.C.

## Cancellation Policy

Effective Date: December 2014

At Paun Family Chiropractic and Wellness, P.C., we have extended hours to accommodate our patients and their increased demands of life.

In return, we request that we be notified twenty four (24) hours before any cancellation. This allows us the opportunity to properly schedule other patients in need of our services and to efficiently work around our own schedules.

A \$25.00 fee will be automatically charged to your account (per occurrence) if this policy is abused. Please note that we will take unforeseen circumstances into consideration and that this is mostly in effect for people who have a tendency to disregard our schedule.

If you have any questions, comments or concerns please feel comfortable to speak with the Drs. Paun to avoid any miscommunication.

We appreciate your cooperation with this matter.

**I understand the cancellation policy of Paun Family Chiropractic and Wellness, P.C. and the fees associated with violation of this policy.**

Signature: \_\_\_\_\_

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

# Paun Family Chiropractic and Wellness, P.C.

## Financial Policy

Effective Date: December 2014

It is our office policy that payment for services rendered is ultimately the responsibility of the patient, whether or not you have third party assistance with your financial obligation. We are happy to extend a payment plan to you so that you can follow through with all the care you may require.

All patient fees are expected at the time of service or according to a preset payment plan or program. Personal balances may not exceed \$300 unless on a pre-arranged payment plan. Payment plans are available to ensure you are able to receive all the care you may require.

For your convenience, this office accepts cash, checks, and the following credit cards: Visa, MasterCard, Discover, and Care Credit.

This office participates in a discount medical plan organization (DMPO) and offers discounted fees to uninsured, underinsured, or partially insured patients who are members. We will assist you in learning more about this should you wish to access these discounted fees.

This office does not turn away any patient due to their ability to pay. If you feel you might qualify for our financial hardship policy, notify the office immediately so we can begin your qualification process.

Should payment be refused by your bank for any check written, this office will charge a fee of \$25.70 or 5% of check amount (whichever is greater) to offset the charges we will incur as a result of the returned check.

Any balance left unpaid after a period of 120 days will be assessed an interest charge of 1.5 percent per month (18% APR).

As a courtesy to our patients, this office will bill third party payers, accept assignment, and wait to be paid for some portion of our patients' financial responsibility.

The privilege of insurance assignment begins when our office receives and verifies your insurance information. Until that time, you are considered a "cash" patient and payment is expected at the time of service. As a courtesy to you, our office will pre-qualify your insurance coverage, in an effort to help you determine what coverage is available to you under your policy. We will help you make the best estimate of your coverage for the recommend services. This service is a courtesy to you and is not a guarantee of coverage.

No one can predict what an insurance company will pay for the usual and customary charges for services rendered. If we participate on your plan, you will not encounter balance billing above the stated fee schedule. If we do not participate, we will work with you to determine the amount of coverage and help estimate your responsibility.

If your insurance has not paid on an assigned bill within 90 days, you will be notified. Since we do not own your policy, we ask that you stay in communication with our office and take action with your insurance company at that time. If it remains unpaid within 120 days the balance becomes due and payable immediately and your assignment is revoked.

All patients whose treatment visitation schedule is once per month or longer will no longer be eligible for insurance assignment as this level of care is rarely covered by insurance. Our office offers numerous payment options to allow you to continue maintenance, wellness, or supportive care.

Should you discontinue care for any reason, other than discharge by the doctor, any and all balances will become due and payable at that time. If you are on a predetermined payment plan, that plan will continue to be in effect until your balance is zero.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Paun Family Chiropractic and Wellness, P.C.

**Join Our Email Newsletter!**

Would you like to join our Paun Wellness email newsletter to receive wellness tips, nutrition advice, office updates, and exclusive offers? (We promise never to spam or sell your email.)

**Yes**

**NO**

If yes, please list your email below:

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# Paun Family Chiropractic and Wellness, P.C.

## HIPAA Notice – Patient Copy

I hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The Privacy Notice of Paun Family Chiropractic and Wellness, P.C. (PFCW) will be provided to me upon my request. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for PFCW to provide treatment to me, and also necessary for PFCW to obtain payment for that treatment and to carry out its health care operations. PFCW has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice prior to my signing this Consent.
2. PFCW reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable laws.
3. I understand that, and consent to, the following appointment reminders or communications that will be used by PFCW:
  - a.) a postcard mailed to me at the address provided by me; and
  - b.) Telephoning my home or cellular phone and leaving a message on my answering machine or with the individual answering the phone.
4. PFCW may use and/or disclose my PHI to the third party (which includes information about my health or condition and the treatment provided to me) in order to treat me and obtain payment for that treatment, and as necessary for PFCW to conduct its specific health care operations.
5. I understand that I have a right to request that PFCW restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, PFCW is not required to agree to any restrictions that I have requested. If PFCW agrees to a requested restriction, then the restriction is binding on PFCW.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocations shall not apply to the extent that PFCW has already taken action in reliance on this consent.
7. I understand that if I revoke this Consent at any time, PFCW has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then PFCW will not treat me.

### AUTHORIZATION FOR RELEASE OF RECORDS

Paun Family Chiropractic and Wellness, P.C. is authorized to disclose to my attorney, or his / her agent, as well as to any insurance carrier who may be liable for payment of bills and charges for services rendered to me, any information which may be acquired by examination, or other means, of my physical and mental condition; and I hereby release PFCW of any consequences thereof.

Due to Federal and State Laws we are required to safeguard your medical information including any diagnostic films (X-rays, MRI, etc). We will send any films to the physician you requested via certified mail and you will be responsible for the postage at the time of the request.