

Billing and Payment

In connection with your chiropractic Treatment, payment may be made by any of the following methods. Please indicate your method of payment below:

_____ Self Pay: if you have no available insurance coverage you will be billed for services provided

_____ Health Insurance: We will bill your health insurance provider if, at the time of service, we are a contracted provider with that insurance company. However, you must remit all payments due as a result of any deductible, co-insurance and/or co-payments per the insurance plan. These payments as well as payments for services not covered under the plan are due at the time each service is rendered.

_____ Third Party Fault: in the event that a third party is at fault for your injury and you wish for us to bill that third party or our automobile medical payments carrier instead of your health insurer, then we will attempt to collect from the third party at the full cost of our services. However, in the event that the third party recovery is unsuccessful, then you will be responsible for the full amount of the outstanding medical bill.

Patient's printed name: _____

Patient's signature: _____

Patient's representative (if a minor) _____

Relationship to patient: _____

Date: _____

Name of attorney if represented _____



Mayfield

Chiropractic West

CHARLES W. MAYFIELD D.C.

4707 Cypress St., West Monroe, LA 71291

Phone: (318) 396-5558 Fax: (318) 396-9119

Notice of Health Information Privacy Practices

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

UNDERSTANDING YOUR HEALTH RECORD AND INFORMATION

Each time you visit a healthcare provider, a record of your visit is made. Typically this record contains your symptoms, examination and test results, diagnoses, treatment, and plan for future care or treatment. This information is often referred to as your health or medical record and serves as a basis for planning your care and treatment, a means of communication among the many health professionals who may contribute to your care by which you or a third-part payer can verify that services billed were actually provided, and a tool for which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your records and how your health information is used helps you ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request a restriction of certain uses and disclosures of your information as provided by 45 CFR 164.522, although this entity is not required to agree to any requested restriction.
- receive confidential communications of protected health information as provided by 45 CFR 164.522
- obtain a paper copy of the notice of information practices upon request
- inspect and obtain a copy of your health record as provided for in 45 CFR 164.524
- amend your health record as provided in 45 CFR 164.526
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken

OUR RESPONSIBILITIES

This organization is required by law to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We may also use your health information to contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization, if given, as provided by 45 CFR §508 (b)(5).

We will not use or disclose your health information without your authorization, except as described in this notice.

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS

We will use your health information for treatment. For example: information obtained by a nurse, physician.

(This is your copy to keep)



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I acknowledge that I have received the patient privacy act, rights, and responsibilities information. This information was provided to me on my initial visit.

Patient Signature

Date

Parent & or Guardian

Date

Witness

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INFORMED CONSENT

I (we) hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me or on _____, by Charles W. Mayfield, D.C. and/or other licensed doctors of chiropractic who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor or other clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand the practice of neither chiropractic nor medicine is an exact science, and that my care may involve the making of judgments based upon the facts known to the doctor to be able to anticipate or explain all risks and complications, that an undesirable result does not necessarily indicate an error in judgment, that no guarantee as to results has been made to nor relied upon by me, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I further understand that there are certain degrees of risk associated with chiropractic health care including, but not limited to, fractures, disc injuries, strokes, dislocation, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read or have had explained to me the above content. I have also had an opportunity to ask questions about its content and by signing below agree and intend with this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Patient Signature

Patient Name

Witness

**Relationship to or authority
if not signed by patient**

Date



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Appointment Reminder and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not available, a voicemail will be left for you. By signing this form, you are giving us the authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke authorization to us at any time; however, your revocation must be in writing and mailed to our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims. Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we used to contact you to provide appointment reminders, information about treatment alternatives, or health related information at any time (164.524).

This notice is effective as of the date signed below. This authorization will expire six years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. A copy of this authorization will be provided to you upon request.

Patient name (Printed)

Date

Patient Signature

Authorized Provider Signature

Personal Representative (Printed)

Person Representative Signature

Today's date:

PATIENT INFORMATION					
Patient's last name:	First:	Middle Initial:	Nickname:	Date of Birth:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Work Phone:	Home Phone:	Preferred Phone: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell
Address Line 2:			Cell Phone:	Occupation:	
City:	State:	Zip Code:	Social Security:		

Referred to this office by:

- Yellow Book
- Yellow Pages
- Location
- Online
- Mail
- Social Media (Check One): Facebook _____ Instagram _____
- Friend/Family Member: _____

Please select:

- Health Ins.: _____ Policy Holder: _____ DOB: ____/____/____
- Auto/WC Ins.: _____ Claim No. _____
Contact: _____ No. (____) _____ - _____
- Attorney: _____ No. (____) _____ - _____
- Self-Pay

Marital Status: Partnered Divorced Widowed Other Single Married

Preferred Language:

- English Spanish German French
- Italian Russian Portuguese Chinese
- Japanese Korean Vietnamese Other _____

Please check ALL races that apply:

- White
- Black or African American
- American Indian or Alaska Native
- Asian
- Native Hawaiian/Pacific Islander
- Decline to Answer

Ethnicity:

- Hispanic or Latino Non-Hispanic nor Latino Declined to Answer

Smoking Status:

- Current everyday Current some days Never Former Start Year _____ Quit Date _____

Current Medications:

- NONE
- Provide Copy of List
- List Below

Medications Allergy:

- NONE
- List Below

Family History

Please indicate which of the following exist or have existed by marking the boxes below.

	Self	Mother	Father	Brother	Sister
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient History

Please describe any past accidents or injuries:

1. Accident: _____ Job Auto Other Date: _____
2. Accident: _____ Job Auto Other Date: _____
3. Accident: _____ Job Auto Other Date: _____

Please describe your past surgeries:

1. Surgery: _____ Date: _____
2. Surgery: _____ Date: _____
3. Surgery: _____ Date: _____

Please list any pre-existing illnesses:

1. _____
2. _____
3. _____

Do you have any allergies? Yes ___ No ___ If yes, please list below.

1. _____
2. _____
3. _____

Have you been treated by a physician for any health conditions in the last year? Yes No

If yes, describe the briefly conditions: _____

Date of last physical exam: _____

Do you have any metal: (example) rods, plates, screws? Yes No

Have you ever been gun shot? Yes No

Date of last menstrual period: ___ / ___ / ___ Are you Pregnant? Yes No How far along? _____

SYMPTOMS

List Symptoms

Pain rating (1-10, with 10 being worst imaginable)

1 2 3 4 5 6 7 8 9 10

1 2 3 4 5 6 7 8 9 10

1 2 3 4 5 6 7 8 9 10

1 2 3 4 5 6 7 8 9 10

1 2 3 4 5 6 7 8 9 10

Have you ever had these symptoms before: Yes Date: _____ No

Patient Signature: _____

Date: _____